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FAY (cont'd)

ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND
RELATED MATTERS.

Hearing held
8th floor
180 Dundas Street West
Toronto, Ontario

In ch. EAC
X Cecchetti

The Honourable Mr. Justice S.G.M. Grange
P.S.A. Lamek, Q.C.
E.A. Cronk
Thomas Millar

Commissioner
Young
Counsel
Associate Counsel
Brown
Administrator

Transcript of evidence
for
November 23, 1983

Shirley

VOLUME 68

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ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN
AND RELATED MATTERS.

Hearing held on the 8th Floor,
180 Dundas Street West, Toronto,
Ontario, on Wednesday, the 23rd
day of November, 1983.

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner
THOMAS MILLAR - Administrator
MURRAY R. ELLIOT - Registrar

APPEARANCES:

P.S.A. LAMEK, Q.C.)	Commission Counsel
E. CRONK)	
T.C. MARSHALL, Q.C.)	Counsel for the Attorney
D. HUNT)	General and Solicitor General
L. CECCHETTO)	of Ontario (Crown Attorneys
	and Coroner's Office)
I.J. ROLAND)	Counsel for The Hospital for
M. THOMSON)	Sick Children
R. BATTY)	
D. YOUNG	Counsel for The Metropolitan
	Toronto Police
K. CHOWN	Counsel for numerous Doctors
	at The Hospital for Sick
	Children
F. KITELY	Counsel for the Registered
	Nurses' Association of Ontario
	and 35 Registered Nurses at
	The Hospital for Sick Children

(Cont'd)



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APPEARANCES: (Continued)

D. BROWN	Counsel for Susan Nelles - Nurse
G.R. STRATHY) E. FORSTER)	Counsel for Phyllis Trayner - Nurse
J.A. OLAH	Counsel for Janet Brownless - R.N.A.
B. KNAZAN	Counsel for Mrs. M. Christie - R.N.A.
S. LABOW	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes, and Mr. & Mrs. Murphy (parents of deceased children)
F.J. SHANAHAN	Counsel for Mr. & Mrs. Dominic Lombardo (parents of deceased child Stephanie Lombardo); and Heather Dawson (mother of deceased child Amber Dawson)
G.R. SOLOMON	Counsel for Mr. & Mrs. Hines (parents of deceased child Jordan Hines)
J. SHINEHOFT	Counsel for Lorie Pacsai and Kevin Garnet (parents of deceased child Kevin Pacsai)

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EMT/ak

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---Upon commencing at 10:00 a.m.

3

DR. JOHN E. FAY, Resumed

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THE COMMISSIONER: Yes, Miss Cronk?

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MS. CRONK: Good morning, sir.

6

Good morning, Doctor.

7

DIRECT EXAMINATION BY MS. CRONK: (Continued)

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Q. Doctor, you will recall yester-

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day that when we broke we had completed a discussion
with respect to seven cases where you had concluded

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that digoxin intoxication was either the probable

11

cause of death or there was a high suspicion that

12

this was the case.

13

In addition we considered the case of

14

Jordan Hines where you ultimately concluded that

15

there was a good possibility that digoxin toxicity
had caused his terminal event.

16

Is there any other case, Doctor, of

17

these 36 children whose cases you reviewed other

18

than those eight which we discussed yesterday where

19

you considered it probable or highly suspicious or

20

a good possibility that digoxin intoxication had

21

caused or had directly contributed to the death

22

of the involved child?

23

A. No, no other probabilities or

24

good possibilities. The rest are in a lower category,

25



1
2 either C or whatever.

3 Q. Well, Doctor, with respect to
4 those lower categories, as I understand it there are
5 four cases where you felt that there was a possibility
6 or a suspicion that digoxin intoxication had been
7 involved in the death of the child, and I'm referring
8 to the cases of David Taylor, Brian Gage, John Onofre
9 and Real Gosselin.

10 I would ask you to turn first, if you
11 would, to the case of David Taylor. Your handwritten
12 notes, Doctor, with respect to this child begin at
13 page 9.

14 Once again, Doctor, as I have asked
15 you with respect to the other children we have
16 discussed could you outline for the Commissioner if
17 you would those factors which you consider to be
18 significant in assessing this case?

19 A. The child had again severe
20 congenital heart disease, and on the day of his
21 death it was recorded in the chart that he vomited
22 a small amount and then - that was the 27th of July,
23 1980 - and then shortly after developed an arrhythmia,
24 sinus tachycardia, variable AV block, Wenkeback
25 periods which is heart block, ventricular heart block,
a type of, and then went into ventricular fibrillation.



1
2
3 I think it was because of that mode
4 of death and the arrhythmia that I felt this was a
5 possibility.

6 I think one thing that really did
7 interest me here was Dr. Izukawa's note written on
8 the 27th of July. The baby had had digoxin and
9 furosemide and diuretics, and there was a note that on
10 auscultation the heart rhythm was variable, the
11 rhythm strip showed an arrhythmia.

12 The PR interval was a little long I
13 think for the rate which again might be a manifesta-
14 tion of digitalis. Might be a manifestation in a
15 very young baby of digitalis excess. Then he went
16 into a heart block and then stabilized. Showed ST
17 segment depression which might have been due to
18 digitalis. Became more progressive and went into
19 ventricular fibrillation which is cardiac arrest.

20 Now the baby had regurgitated and
21 aspirated and it was thought that he was hypoxic on
22 that basis that the arrhythmia had occurred, and
23 Dr. Izukawa reviewed the medications and said no
24 evidence of overdosage or error in dosage which
25 suggested to me that clearly he had considered the
possibility, and I thought that - I thought, too,
there was a possibility especially in view of



1
2 Dr. Izukawa's specifically raising the question.

3 I take it then, Doctor, that
4 Dr. Izukawa's note that appears in the medical record
5 of the child and the comments which he made were of
6 significance to you in formulating your opinion in
7 this case.

8 A. Yes.

9 Q. And, Doctor, at the September
10 13th meeting held in 1982, in the part of the minutes
11 that records the discussion of David Taylor, at page
12 230, you are quoted as having said that Dr. Izukawa's
13 note showed that he was obviously perplexed; no
14 evidence of overdosage, and you felt that the note
indicated that Dr. Izukawa was thinking of digoxin.

15 Was that your view, Doctor, after you
16 had read the medical record of the child and
specifically Dr. Izukawa's note?

17 A. There is no question at all
18 that Dr. Izukawa's comments swayed me in my assessment
19 of this infant's death; that he was thinking of that,
20 the child had had digoxin, and the child's death was
21 compatible with it, so in the setting that we have
22 been describing I put it as suspicious but not as
23 highly suspicious as some of the others or probabili-
24 ties that we talked about.
25



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2
3 The child had very severe heart
4 disease and these babies very frequently die of their
5 heart disease within a few weeks of birth.

6 Q. Doctor, at the September 13th
7 meeting your vote with respect to this child as you
8 have indicated, it should properly be placed in the
9 suspicious category.

10 When we turn to your index cards,
11 however, with respect to your categorization which
12 is at page 4, Doctor, I had again some difficulty
13 in understanding precisely what your classification
14 was. There appears on your index card to be both an
15 A and a B+ and the word "probable" appears but is
16 crossed out and the word "suspicious" appears, not
17 crossed out, with an arrow beside it.

18 Can you tell me, Doctor, at some
19 point either prior to the September 13th meeting or
20 at the September 13th meeting did you consider that
21 it was probable that digoxin intoxication had caused
22 or contributed to the death of David Taylor?

23 A. The A and B, you know, we went
24 over it yesterday, and we came to the conclusion
25 that Dr. Hastreiter - Dr. Hastreiter's good or high
was A or B. You know, it was very confusing at this
stage. I think my initial feeling was that it was
probable. I was persuaded by Dr. Izukawa's note in



1
2 this infant. There is no question about that. By
3 his clinical note. And as with some other cases
4 which we have gone over I changed. This time I
5 changed to suspicious.

6 When I dictated my final notes some
7 weeks later I didn't alter my grading or category,
8 and that is what appears on my typed - on the typed
9 summary.

10 Q. Doctor, you have told us that
11 you were very swayed by the contents of Dr. Izukawa's
12 note. You have told us as well that the particular
13 mode of death, together with the nature of the
14 arrhythmia that this child had suffered had led you
in the first instance to be suspicious.

15 Do I take it then that those two factors
16 in combination when you first reviewed the chart led
17 you to feel initially that digoxin was probably
involved in the death of this child?

18 A. Yes, it did.

19 I didn't discuss this, of course, as
20 you know, with Dr. Izukawa. I discussed none of
21 these with any of the physicians who looked after
22 these children, and I must repeat to you again I am
23 looking at these charts in a really different
24 perspective and I am looking only at the chart, and
25



1
2 I have to make a decision did digoxin play a part in
3 this child's death? Was it probable? Was it
4 possible? Was it highly suspicious?

5 When we move out of the "probable" we
6 move into a very grey area. It may be light grey at
7 times and dark grey, but really the shades of grey
8 may vary and they may vary from day to day as you
9 read that same chart.

10 All I can say is that Dr. Izukawa's
11 note influenced me, and I think from what is written
12 on my little card that has all been Xeroxed and all
13 my hieroglyphics and so on, I changed my grading down,
14 and I probably realized that I had been unduly
15 influenced by that note. But there was no conversa-
16 tion with Dr. Izukawa, no discussion. Merely what
17 he wrote, and I was looking at the chart in a
18 specific context which you know all about.

19 Q. I take it then, Doctor, that
20 as best you can recall it there was no additional
21 information or further data provided to you at the
22 September 13th meeting that caused you to reduce
23 the category from probably to suspicious. Is that
24 correct?

25 A. We are talking about the
consensus again I think.



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Q. I take it then your answer is
yes, Doctor?

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A. Yes.

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Q. All right. Doctor, as you are
perhaps aware Dr. Izukawa testified before this
Commission concerning a number of cases with which
he had been involved including that of David Taylor.

9

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For your assistance I would like to
read to you a portion of his evidence specific to
David Taylor.

11

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Mr. Commissioner, this is found in
Volume 59, page 3204.

13

14

Dr. Fay, Dr. Izukawa was asked this
question:

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"Do you recall, Doctor, at the time
that you attended at the Hospital at
the arrest of David Taylor, after
the child had been pronounced dead,
taking the occasion to review the
medication which had been prescribed
to the child, including the doses of
digoxin that had been prescribed?

22

A. Yes.

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Q. Why, in this case, did you do
that, Doctor?



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"A. Because of the rhythm disturbances that were noted in the period prior to the arrest.

Q. Were you concerned at that time, Doctor, to determine whether or not there had been an error made in any of the medication which had been prescribed to the child including in the digoxin medication that had been prescribed?

A. That is correct.

Q. I take it, from the language of the conclusionary remarks in your arrest note that you were concerned to determine, first that there had not been an overdosage, that is the administration of too much of a prescribed drug for the child and, secondly, that there had not been an error in the amount of the dosage that had been calculated and then administered?

A. That is correct.

Q. Do I have that correctly?

A. Yes.



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"Q. And you had specifically in mind at that time, amongst other medications that had been prescribed, the digoxin medicine that had been prescribed and administered to him?

A. That is correct.

Q. Was it your normal practice, Doctor, when called in as the senior staff cardiologist on call, when called in to an arrest to undertake a review of the medications which had been prescribed and administered to the particular patient?

A. If there is reason to suspect that it might have been due to medication such as with the rhythm changes I would normally do that.

Q. In this case, Doctor, you mentioned that there were rhythm changes. Were those changes the factors that led you to undertake a review of the medication that had been ordered and prescribed?

A. That is correct.

Q. What specifically about the



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2

"rhythm changes in this child caused
you concern?

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A. The occurrence of tachycardia
with the degree of block.

5

6

Q. The second degree A-V block?

7

A. Yes, and also with the changes
in the ST segments which were occurring
at that time."

8

9

Then he was asked this question, Doctor:

10

"Q. Doctor, was the factor of those
particular kinds of rhythm changes
happening at all of concern to you
or was it something to do with the
combination of those rhythm changes
that struck you as being of potential
concern?

11

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A. It was the combination of the
change that I mentioned.

17

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Q. Was that combination, in your
view, unusual?

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A. Not unusual, but realizing that
one of the causes of such a change
might be medication, I reviewed that."

21

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B: 1
BM:
yk 2

"Q. And Doctor, after you had undertaken your review of the digoxin which had been administered to the child, what conclusion did you reach?

A. I concluded that the dosages were correct as recorded in the Order Sheet and therefore that the rhythm disturbances were probably related to the patient's basic underlying lesions."

Dr. Fay, I appreciate that Dr. Izukawa's views with respect to the note that he had made and the action he took were previously not available to you, but now being informed as to what Dr. Izukawa's evidence was in that regard, does his evidence in any way affect your opinion as to the possible involvement of digoxin intoxication in the death of this child?

A. I would have expected Dr. Izukawa, being the physician that he is, to have done precisely what he did and I think in his position I would hope that I would have done the same and I think I would have come to the same conclusion.

I can only repeat that I am looking at this from a different point of view and, with all due



1
2 respect to Dr. Izukawa, I cannot then take that as
3 evidence that there was no digitalis intoxication.
4 It is completely impossible for me to adopt that
5 tack because I found in none of these charts any
6 evidence of digitalis overdosage in the dosages
7 that were recorded and was recorded as given to the
8 infant in the orders. When there was a high
9 digoxin serum concentration invariably this was
10 recognized and digitalis was withheld.

11 So, I don't know whether I am making
12 it clear but from my point of view, although I very
13 much respect, and he has done exactly what I would
14 have expected him to do, I cannot remove entirely
15 suspicion because Dr. Izukawa was suspicious, he
16 felt at the time that he had reviewed things and
17 that therefore he attributed the arrhythmia, the
18 death to the child's serious congenital heart
19 disease, which may have been the case, of course.
20 But I cannot say that I can do away with all
21 suspicion in the setting in which I am asked to look
22 at the chart from the point of view of whether
23 digitalis was a factor in the child's death, I
24 can't do that.

25 Q. Doctor, we have seen in the
other eight cases that we have previously discussed



1
2 that in each and every one there was available for
3 consideration toxicological data concerning digoxin
4 levels or digoxin concentrations found in the
5 various tissues from those eight children. Insofar
6 as I am aware, there is no toxicology data available
7 in the case of David Taylor. Does that accord with
8 your understanding, Doctor?

9 A. I have no information of any
10 toxicology.

11 Q. All right. Did that feature,
12 Doctor, that is, the absence of toxicology data,
13 have any relationship to the reduction of this
14 child's classification from probable to suspicious
15 only?

16 A. Well, from the cases we have
17 reviewed to date, if you are going to tell me that
18 an immediate ante mortem or post mortem sample
19 shows a level of 79 nanograms per millilitre I am
20 going to move this case on my review into Category 1
21 or probable cause of death. That is precisely
22 what I have been doing.

23 Q. I am sorry, Doctor. Could we
24 focus for a moment again on the September 13th meeting.
25 You have told us that going into the meeting your
best judgment at the time was that this case had to



1
2 be classified as probable without more and then at
3 the conclusion of the discussions on September 13th
4 there was a consensus that the case be classified
5 as suspicious and that indeed is how you then
6 classified the case.

7 My question to you is, did the fact
8 that there was no toxicology data available on the
9 case cause the case to be reclassified down to
suspicious?

10 A. I think I would have to answer
11 yes to that. I would like to just say here, these
12 minutes were written 14 months ago, or typed
13 thereabouts, Commissioner. I did not see them until
14 last Thursday.

15 Q. All right, Dr. Fay, I
16 appreciate that and please accept from me that we
17 are grateful for whatever assistance you can provide.

18 Doctor, with respect to Dr. Izukawa's
19 concerns, which you noted, he obviously was
20 concerned by the rhythm changes which he had noted
21 in this child. You have told us that one of your
22 concerns was the particular mode of death of David
23 Taylor. Could you elaborate for us, Doctor Fay,
24 on what specifically it was in the mode of death
25 that caused you to be suspicious.



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A. I am only referring there to the arrhythmia, AV block, tachycardia, AV block, Wenkeback periods which I presume have been explained.

Q. Yes.

A. Ventricular fibrillation.

Q. Were you concerned as well Doctor by the changes in the ST segment to which Dr. Izukawa had referred?

A. Well, yes, of course, that is something that we see with digitalis effect, quite apart from digitalis toxicity and ST segment depression, the cardiogram can have several causes other than digitalis, but taken as I read the account it certainly would fit with digitalis toxicity.

Q. Doctor, you have heard that Dr. Izukawa's conclusion when he had reviewed the matter was that those rhythm changes in combination could be explained by the patient's underlying cardiac lesions. Are you in a position, based on your review of this case, to offer us an opinion in that regard?

A. Oh, they could be based on the



1
2 serious heart disease that this child had,
3 certainly, no question about it. But I am finding
4 it very difficult to get the point across. I
5 don't know quite how to get the point across.
6 I wasn't asked to review the clinical course,
7 I wasn't asked to review the anatomical diagnosis,
8 whether the management had been correct and, in fact,
9 if I had been asked to do it I wouldn't have taken
10 on the task. I was asked to look at the charts
11 and that's all I looked at and have the toxicology
12 when it was available to me to determine whether
13 in my opinion there was a probability, a suspicion,
14 a low suspicion or whether really we should
15 attribute this to natural causes. That is what
16 I was asked to do and that was what I tried to do.

15 Q. Doctor, fairly, as I understand
16 it, and perhaps this should again be clarified,
17 your evidence has been that you understood that
18 you were being asked to review all of these cases
19 to assess the possible involvement of digoxin
20 intoxication. Do I have that correctly?

21 A. Yes, yes.

22 Q. All right. And you were not
23 asked, as I understand it, Doctor, to assess these
24 cases to determine the cause of death at large, is
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that correct?

A. That is correct as I understand it, yes.

Q. Thank you, Doctor. Doctor, could I ask you to turn for a moment if you would, please, to page 27 of the medical record of David Taylor. Mr. Registrar, could you provide that chart to the doctor.

At page 27, Doctor. It is difficult to read it, Doctor, the numbers at the top of the right-hand page are small.

A. Oh, is this the number here?

Q. Yes, page 27. This is a medication sheet with respect to David Taylor which records amongst other matters the medications which he received the day prior to his death. It indicates that at 5:00 a.m. he received .7 milligrams of digoxin, at 1700 hours he received .025 milligrams of digoxin, 10:00 a.m. he received 5 milligrams of Lasix and at 2200 hours he received another 5 milligrams of Lasix. Do any of those doses, Doctor, in those amounts, assuming that they were administered in those amounts, cause you any concern?

A. No.



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Q. All right, thank you, Doctor.

I take it then, Doctor, that with respect to David Taylor the particular pattern of the arrhythmias that he suffered as part of his terminal events, together with what you understood to be the question in Dr. Izukawa's mind led you to conclude there was this suspicion of digoxin intoxication in this case and that remained your view today. Do I have that correctly, Doctor?

A. Yes.

Q. Thank you, Doctor. May we turn then to the case of Brian Gage. Your handwritten notes with respect to this child begin at page 37. I would ask you once again, Doctor, if you would, please, to outline for us what factors you considered to be of significance in categorizing this case?

A. Well, again, I wasn't looking at it from the management of the congenital heart disease which is again severe as shown by the autopsy diagnosis, transposition of the great arteries and so forth.

The baby died September 25th, 1981, vomited, then went on to develop a slow heart rhythm, which was resuscitated - arrested, actually, at 0335, was resuscitated, bradycardia recurred,



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Fay, dr.ex.
(Cronk)

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slow heart rhythm recurred, baby died about half-an-hour after that at 0400 hours on the 25th of September at age four weeks.



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The digoxin levels on the 7th, 8th and 11th were within the therapeutic range. The digoxin level on the 24th of September, the day before the baby died, was on the high side at 3.5.

Again looking at it as I was looking at it, I placed this as a suspicious. I was perhaps wrongly swayed I think by the toxicology - three specimens from the GI tract, 1,100 nanograms per millilitre. Mr. Cimbura didn't know what to make of that, it is true. The serum taken just before the baby died I think was 1.6, which was low, nanograms per millilitre.

I think perhaps I was unduly swayed by the 3.5 digoxin level the day before death. Certainly the baby's terminal event and cardiac arrest could have been the result of digitalis overdosage. It is not inconsistent with digitalis overdosage but once again this child had severe congenital heart disease.

Q. Doctor, if I have understood your comments then, there were possibly two features which caused you to have a suspicion in this case. The first was the ante mortem digoxin level the day before death of 3.5 nanograms and as



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well the toxicology data. Do I have that correctly?

A. Yes, that is right.

Q. And, doctor, I believe you indicated that there was a serum level taken, I think you said the day before death --

A. Well, I have it here. Yes. Oh, I beg your pardon. I think that is one month before death.

Q. That is right, doctor.

A. I'm sorry.

Q. My understanding is it was well in advance of the child's death.

A. I am sorry, it is a month before death, yes.

Q. Doctor, having now had an opportunity to review again -- I'm sorry, to review the Minutes of the September 13th meeting and specifically Mr. Cimbura's comments with respect to the toxicology data, are you still of the view that there is, in this case, cause to be suspicious as to the involvement of digoxin intoxication?

A. You know, I haven't reviewed these in any detail. I am a busy practitioner and I didn't get all this until last week, and I just



Fay
dr.ex. (Cronk)

C3

1
2 haven't had a chance to review them in detail. I
3 saw these for the first time last Thursday in your
4 office, and I haven't been poring over them since.
5 I came here at short notice to accommodate the
6 Commission and I haven't had a chance to review
7 these in detail. I have had a lot of other
8 reviewing to do but I have not reviewed these in
9 detail and the first time I saw them was last
10 week, so you must forgive me if I take a little
11 time now to read them.

12 Q. I understand completely.
13 Take as much time as you feel you need.

14 My reference specifically is to
15 the bottom of page 228, where Mr. Cimbura's
16 comments with respect to the toxicology data are
17 set out.

18 You yourself had indicated a
19 moment ago, and judging from the Minutes correctly,
20 that Mr. Cimbura had some doubt as to what the
21 toxicology data could properly be taken to mean.

22 A. Yes. Well he didn't know
23 what to make of it, so if he didn't know what to
24 make of it, I presume nobody else present really
25 knew what to make of that. In fact I think he
said eventually that the GI content was nothing



1
C4 2 inconsistent with the normal dose.

3 Q. Given Mr. Cimbura's
4 comments, doctor, concerning the toxicology data,
5 do they in any way cause you to reconsider the
6 view that there is reasonable grounds in this
7 case to be suspicious regarding the possible
involvement of digoxin intoxication?

8 A. Well I have now entered
9 this grey area and I would like to remove this
10 child from the dark grey to the light grey; I
11 would like to put him down in 4, low suspicion.

12 Q. Thank you, doctor.

13 Doctor, you will recall that
14 yesterday we discussed, for example, the case of
Janice Estrella.

15 A. Yes.

16 Q. Where we know that four
17 days prior to her death she had an ante mortem
18 digoxin level of greater than 9.4 nanograms.

19 A. Yes.

20 Q. And you and I agreed yester-
21 day that she lived obviously for another four
22 days until January 11th.

23 A. Yes.

24 Q. I take it that the fact, in
25



C5

1
2 this child's case, that she had a level of 3.5
3 the day before death, of and in itself, would not
4 in your view indicate digoxin intoxication contri-
5 buting to death?

6 A. Not really. You know
7 again, if you just showed me this in isolation,
8 I am not going to get wildly excited. If this is
9 a baby on my service and you tell me the digitalis
10 level is 3.5 nanograms per millilitre, I would
11 want to know when that was taken in relationship
12 to, you know, whatever dosage the baby is on. But
13 I am not going to get terribly anxious about that.
14 I will be more anxious if you tell me that's a
15 level in an eighty-eight year old with renal
16 impairment and perhaps some cardiac arrhythmia
17 to start off with. No I wouldn't be, and I can
18 only say again, and I am trying to be as clear as
19 I can, that I was looking at it from one specific
20 viewpoint, not from the clinical management per
21 se.

22 Q. I understand, doctor, and I
23 thank you.

24 Could we turn now to the case of
25 John Onofre, and your notes with respect to this
child commence at page 51.



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Once again, doctor, with the benefit of your notes and your case review, could you outline for us if you would the factors which you considered to be significant in categorizing this case.

A. The baby was age eighteen days at the time of death. The baby once again had severe congenital heart disease, pulmonary atresia and patent ductus arteriosus and he was found at autopsy to have pulmonary atresia and an extreme degree of tetralogy of Fallot, which again I am sure Dr. Rowe has explained to everybody. The baby had some congestion of the lungs post mortem.

The death occurred on the 9th of December 1980 with the sudden onset of bradycardia and cardiac arrest. The morning of December 9th, I am not sure how long that was before death occurred, the heart rate dropped 40 to 50, once again bradycardia. Previously, the baby's rate had been 120 up to a slight tachycardia, at 170 and then the baby went into asystole, from my notes.

Now I believe at autopsy changes were found in the myocardium which would have explained the arrhythmia. The baby had some



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sepsis, at least escherichia coli organism was cultured from different sites. The dosage of digoxin as it was ordered, as I recorded it here, was within the therapeutic range, was in the normal range, and the only thing here to raise any suspicion, again in the setting in which I am reviewing the chart, was that the baby was relatively stable and then suffered this sudden onset of arrhythmia, so that I had to consider there was a suspicion.

Q. Doctor, I take it from what you have just said that, as part of your review of this case, you did review the doses of digoxin which had been prescribed for the child and found them to be, as you have described them in your case review, moderate?

A. Yes, I did.

Q. And, doctor, you have told us as well that having regard to the apparent stability of the child prior to his demise and the pattern of his death, you felt there was some suspicion in this case?

A. Yes. You see I am not looking at this child to see whether the cardiac group at The Sick Children's Hospital are ordering



C8

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2 normally accepted doses of digitalis - I know
3 they do that. It is interesting mind you that
4 over the last twenty years, overall, the dosage
5 for infants in the last 25 years has tended to
6 come down. I think it is true that 20 to 25 years
7 ago larger doses were given but of course at
8 that time we didn't have the ability to measure
9 the serum digoxin concentrations. I am not look-
10 ing at it from that point of view. I do have to
11 look at the dosage - I am not expecting to find
12 an error in dosage, as can occur; of course they
13 occur, but I am not expecting to find that, and I
14 didn't find it. So really in forming my
15 opinion, in giving the opinion I have been asked
16 to give, I cannot really weight the orders for
17 digoxin in my assessment; I really cannot weight
18 the orders. I expected to find them and I did
19 find them in the normal range as ordered.
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Q. Thank you, Doctor.

I take it, however, that if in the course of a chart review of any particular child you were to see in the chart an indication of what you felt to be an extraordinarily high or a too high dose, that would be a relevant factor?

A. Yes, it would be relevant, but I didn't expect to find that, and in fact I didn't.

Q. And in this case you didn't?

A. In no case did I find it.

Q. Thank you.

A. In dosage orders. Not that I recall.

Q. Thank you, Doctor. That was my question, Doctor, thank you.

Doctor, with respect to the proceedings at the September 13th meeting your vote in this case is recorded as placing the child as you have just indicated in the suspicious category?

A. Which page is that?

Q. 231 of the minutes, Doctor.

THE COMMISSIONER: There is some difference in your numbering and mine, Miss Cronk. I am at page 230 and I noticed that before.



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MS. CRONK: I'm sorry, sir, the discussion with respect to John Onofre commences at page 230. The vote is set out on page 231.

THE COMMISSIONER: It is the other way around. It commences at page 229, and 230. Can we take a vote on who has what? But is it page 13 of the ---

MS. CRONK: That is correct, sir.

THE COMMISSIONER: I wonder as I have got it differently could we change to those numbers?

MS. CRONK: Certainly.

THE COMMISSIONER: Numbers 12 and 13?

MS. CRONK: Certainly, sir.

Q. Doctor, you have page 13?

A. Yes, I have.

Q. All right. Doctor, in the discussion section of the minutes it is indicated, and I am referring now to the fourth full paragraph:

"There was some discussion on the use of the term 'unexpected'. Dr.Fay stated that one must be careful with this term. This baby had severe heart condition with surgery at 2 days of age. He would not call this death unexpected, stating there are degrees



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"of unexpectancy. Dr. Fay advised that suspicion would come with information on the scenario, times, etc."

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Can you help me, Doctor, as best you can recall what you were referring to when you made those comments?

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A. Well, you see apart from my review of the charts I was introduced to meetings every now and again where other factors were discussed where I didn't really enter into, you know, geographic locations, nursing routines and all that. I think it is fair in view of what was suggested.

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May I make a comment here?

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Q. Please do.

A. You will see that one, two of the six people present thought probable murder; one put highly suspicious. Mr. Cimbura had no comment and two of us called it suspicious.

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I wrote "suspicious" down. I noted what others had said, and when I made my final report as with my previous final reports I did not alter that opinion even though it had been arrived at September, October, November - at least three months before I made my final report. But I didn't



1
2 alter it because I had put it down there and neither
3 would I alter it today except that I might be
4 inclined to put that child too in the Category 4.

5 Q. Can you tell me why, Doctor?

6 A. Simply because I am looking
7 at these notes after a lapse of more than a year
8 and I have looked at the thing again and I am
9 willing to change my mind slightly, and put it into
a slightly lower category.

10 Q. Doctor, for your assistance,
11 as you know, Dr. Richard Rowe has testified at
12 length before the Commission?

13 A. Yes, I know.

14 Q. With respect to this child
15 he testified that following completion of the
autopsy ---

16 A. Yes.

17 Q. - he was not surprised by the
18 timing of this child's death.

19 This evidence, Mr. Commissioner, is
20 at Volume 14, page 2480, and he indicated at
21 autopsy sepsis was clear; there was evidence that
22 the child's shunt was too small and it was suggested
23 there had been damage to his heart muscle causing
the arrhythmias which had preceded his actual death.

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I take it, Doctor, that you did have an opportunity as is apparent from your handwritten notes to review the autopsy results in this case?

A. Yes, I did.

Q. All right. Doctor, with the benefit of Dr. Rowe's evidence, are you in a position to express any opinion as to whether or not the findings at autopsy offer what you feel to be a reasonable explanation for this child's death?

A. Yes, they can offer a reasonable explanation, yes, they can.

Q. Thank you, Doctor.

Doctor, may we turn then to what I understand to be the last case which you place in the possible or suspicious category; that of Real Gosselin.

A. Yes.

Q. Your notes with respect to this child commence at page 57.

Once again, Doctor, the question I am sure that will not come as a surprise to you, could you with the benefit of your notes and case review outline for us those factors that you considered to be of significance in categorizing this child's death as suspicious?



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2 A. Frankly, no. I like to start
3 off at the bottom of a page. Just as I was
4 influenced by Dr. Izukawa's note, Dr. Bob Freedom's
5 note certainly influenced me in assessing this
6 child because Dr. Bob Freedom said in a letter
7 to Dr. Gordon Cumming in Winnipeg that he was
8 surprised at the baby's demise a few hours prior
9 to surgery, doubted that it could be explained
10 by apnea, secondary to prostaglandin therapy,
11 and I really don't have any good explanation for
the baby's sudden deterioration and death.

12 And, you know, I think that was one
13 of the major factors in making me in the context
14 in which I was reviewing this chart put this in
15 the suspicious category.

16 The baby had a severe coarctation,
17 with a preductal coarctation I think it was, the
18 ductus forming the major supply to the lower body
19 about which the Commission has been informed in
detail I know.

20 Now the baby had had a high digitalizing
21 dose I believe before the baby left Winnipeg.
22 The baby had had a high digitalizing dose, and
23 on admission the digoxin was held but it was still
24 3.9 nanograms per millilitre at some time after
25



1
2 the last dose of digoxin, and I don't know the
3 interval between the cessation of digoxin, stopping
4 digoxin and the taking of that blood sample, and
5 then at 0225 on the 18th, again we get this brady-
6 arrhythmia, it is resolved; it is repeated five
7 minutes later; the baby arrests and resuscitation
goes on for 45 minutes but is unsuccessful.

2 8 So the baby had severe heart disease;
9 the baby had digoxin; the baby was thought to have
10 had too much digoxin at one time. I don't know
11 what that was based on but certainly there was one
12 level of 3.9 after the last dose, and then the
13 baby has an arrhythmia and then Dr. Freedom expresses
surprise.

14 In the context in which I was reviewing
15 the chart I placed it in the suspicious category.

16 Q. Doctor, may we deal with
17 that in stages? You have told us and it is reflected
18 in your handwritten notes that you were aware that
19 a digitalizing dose of digoxin had been administered
20 to this child in Winnipeg prior to its referral
to the Hospital for Sick Children.

21 In your view, Doctor, were the doses
22 of digoxin administered at the referring hospital
23 sufficient to produce extreme toxic symptoms?
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A. I don't know what the total digitalizing dose was in Winnipeg. I don't know what the dose given was. I didn't have that. I put a question mark after TBD as you will see in my notes so I don't know what that was. In fact if it was there I missed it.

Q. Doctor, while I search for that could we deal with ---

A. Neither do I have the baby's weight.

Q. I think I can help you with both of those factors, Doctor.

A. I take it was the opinion of the physician at the Hospital for Sick Children on admitting the baby that the initial digitalizing dose had been high. That was their opinion.

Q. Doctor, the child's birth weight was 2700 grams; the digitalizing dose that had been administered at the referring hospital was 50 micrograms per kilo and it was in Winnipeg; it was administered on December 16th, 1980 at 7:00 p.m.

A. And how was it administered?

Q. I am sorry, Doctor, I will have



1
2 to check that.

3 I'm sorry, Doctor, if you will bear
4 with me for a moment, please? IV push Doctor.
5 In all three instances for a total dose as I would
6 describe it.

7 A. Well, the total dose as you
8 describe it is reasonable. 40, 50 micrograms per
9 kilogram, but usually when we give that dose we
10 are giving it orally and when we give it parenterally
11 or intravenously we usually take about two-thirds
12 of that.

13 Q. I take it it was on the high
14 side?

15 A. On the high side if you like.

16 Q. Having regard to the fact that
17 it was on the high side and particularly having
18 regard to the method of administration would that
19 amount of digoxin in your opinion be sufficient
20 to produce extreme toxic symptoms in this child?

21 A. No.

22 Q. Doctor, you have told us as
23 well in this case you were influenced by and regarded
24 as significant Dr. Robert Freedom's letter to Dr.
25 Miller in Winnipeg?

26 A. Yes.



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Q. The referring physician?

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A. Yes.

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Q. And you have referred at length
in your handwritten notes to what Dr. Freedom in
fact stated in that letter?

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A. Yes.

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Q. To assist you with that, Dr.
Freedom as well testified before the Commissioner
and he has testified that when he wrote that
reporting letter he did not have access to the
medical record of this child and he was relying on
information provided to him by the resident on call
and on his own observations at gross autopsy.

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He testified further that the resident
on call had told him the child was stable and had
seemed to have had a good response to prostaglandin
therapy which had been instituted in the Hospital
for Sick Children. However, when Dr. Freedom
himself had the opportunity to review the medical
record after he wrote that letter it became, as
he described it, very clear to him that the child
had not had a good response to prostaglandin
therapy and in fact was not in stable condition.

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He therefore testified before the
Commissioner that he concluded that the baby died as



1
2 a direct consequence of a severe narrowing of the
3 aorta and died from severe heart failure.

4 That evidence, Mr. Commissioner, is
5 at Volume 29, page 5405.

6 Doctor, having regard to those comments
7 and that evidence by Dr. Freedom, does that infor-
8 mation together with your review of the appropriateness
9 of the digitalizing doses in Winnipeg cause you to
alter your opinion with respect to this case?

10 A. If a cardiologist of Dr.
11 Freedom's stature and experience says this at the
12 bottom of the page I am very much swayed.

13 If Dr. Freedom now says that that
14 was a mistake and he has described a different
15 situation, then I am also very much swayed to
16 the extent that I would now take Real Gosselin
and put this baby into Category 5.

17 Q. That is the natural causes
18 category, Doctor?

19 A. Absolutely, yes.

20 Q. Doctor, I take it just to
21 complete that matter that you are aware that on
22 admission to the Hospital for Sick Children when
23 the digoxin level was taken, digoxin was held at
24 the Hospital for Sick Children; it was not administered
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A. Well, that's all right. The digoxin level is on the high side, you know, if you take the therapeutic range to be in children, say, 1 to 3 nanograms. This is 3.9. We said yesterday that for reasons not clearly understood, certainly not clear to me, children, young children, babies, seem to be able to tolerate a higher level of digoxin than adults without manifesting digitalis toxicity.

Again if you are talking of an old person, 80, 90, with a digoxin level of that degree then I will be concerned, but, no, I wouldn't be terribly concerned. I wouldn't give any more digoxin with that level reported at that until I knew that it had come down, but, no, I think it all fits, and I am prepared to categorize this baby in view of what Dr. Freedom has said as natural causes.

Q. Thank you, Doctor. And I am sorry, perhaps the question wasn't clear. I simply wanted to be clear that when you offered your opinion that you would now categorize the death as natural causes you knew as well that digoxin had been held at the Hospital for Sick Children



1
2 and not administered to this child. You knew that?

3 A. Yes. Again we are coming into -
4 the questions are always clear - we are coming into
5 a situation of dosage at the hospital. Again we
6 checked that dosage in Winnipeg and we said it is
7 on the high side since it was given intravenously.
8 It was held. There was nothing in the chart to
9 indicate anything but a correct clinical approach
10 to the administration of digoxin to this baby at
the Hospital for Sick Children. Nothing at all.

11 Q. Thank you, Doctor.

12 Doctor, as I understand it then
13 apart from those four cases, that is David Taylor,
14 John Onofre, Real Gosselin, that we have just
15 discussed, there were some 11 other cases where
16 you in your conclusions which you recorded in your
17 case reviews felt that there was some degree of
18 suspicion, although you categorized it as a very
low suspicion or unlikely.

19 I don't propose to review these in
20 detail with you, Doctor, but I would like your
21 assistance in explaining to the Commissioner why in
22 each case you felt there was any degree of suspicion?

23 May we start, please, with the case
24 of Laura Woodcock? Your notes on this child start
25 at page 1, Doctor.



E/BM/ak

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3 Can you tell me in this case, Doctor, why
4 you felt there was a possibility, although you have
5 described it as unlikely, that digoxin intoxication
6 had played a part in this child's death?

7 A. Yes, I would like to stress
8 the unlikely. I put a possible with a down-going
9 arrow at low suspicious. The others at the meeting
10 I think had more suspicion than I did. The baby had
11 jaundice, sepsus, pulmonary stenosis, a congenital
12 heart disease and at autopsy had some damage to the
13 heart muscle; nothing much else, and was septic,
14 and had an arrhythmia as a terminal event. Blood
15 pressure came down and the baby developed complete
16 heart block, an arrhythmia which is consistent with
17 digitalis toxicity.

18 There was an exhumation of this baby.
19 Mr. Cimbura examined the skeletal muscle, found a
20 small amount of digoxin. Again, I don't know what
21 that meant to anybody, can't be taken really to
22 influence one's assessment.

23 I retained the possibility of
24 digitalis toxicity in the setting in which I was
25 reviewing the chart mainly in view of the terminal
arrhythmia. I clearly did not feel very strongly
at all. We are well away from the probable category



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2 in this baby's case.

3 Q. Doctor, I refer you as well to
4 the comment that is recorded to have been made by you
5 at the September 13th meeting. This is at page 14 of
6 the minutes:

7 "Dr. Fay referred to the infant's
8 condition -- mild heart disease;
9 believed jaundice was resolving;
10 extensive pneumonia. He was impressed
11 by complete heart block at the moment
12 of death. Dr. Fay stated there was
13 certainly the possibility of digitalis
14 overdose; would not expect infant to
die with mild heart disease."

15 Do you recall making those comments?

16 A. Well, the heart disease doesn't
17 sound too severe, that's true. Well, I don't recall
18 making the comments they were made 14 months ago.

19 Q. I take it, Doctor, that it was
20 clearly your view at the time that this child had
extensive pneumonia?

21 A. That is what it says here, yes,
22 and that is what I have written in my notes I think.

23 Q. She was as well suffering
24 from liver disease?
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A. Yes.

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Q. All right. In your opinion, could either of those factors of and in themselves, Doctor, account for the death of this child at the time and in the manner in which it occurred?

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A. Yes, certainly could.

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Q. Was her heart disease per se sufficient to cause her death, Doctor, bearing in mind the comments which you made?

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A. No, I don't think that - well, the mild pulmonary stenosis, all right, jaundice and sepsus and then there is a sub-endocardial infraction of the left ventricle recorded by the pathologist. That means that death has occurred in part of the heart muscle. So, although the congenital malformation sounds mild, there was damage to the muscle of the heart. Exactly what caused that is not clear. The baby was septic. I think when I looked at this again, this baby could well have died of the conditions which are listed here.

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Q. All right.

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A. The heart disease itself, apart from the infraction, the congenital malformation does not seem to be severe. But the baby had a possible aspiration, had a pneumonia, was septic and



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2 had damage to the heart muscle.

3 Q. Doctor, what significance did
4 you attach to the fact that the child had complete
5 heart block at the moment of death?

6 A. Only the significance that this
7 is a possible manifestation of digitalis toxicity,
8 that's all, that's all. The baby was noted to die
9 with a complete heart block. That doesn't mean to
10 say that it was caused by digitalis, but it is
11 possible, it's possible, that's all, nothing more.

12 Q. On reflection, Doctor, and on
13 reviewing again your notes of this case and the
14 minutes of the September 13th meeting, are you
15 inclined to the view that it is most likely that the
16 child died on account of her disease condition?

17 A. Yes, because I think in fact
18 looking back, insufficient attention was paid to the
19 other factors that are listed here. The sepsus and
20 the injury which the pathologist recorded at the
21 autopsy of sub-endocardial infraction of the left
22 ventricle, which could certainly give rise to that
23 arrhythmia.

24 Q. Doctor, may we turn then to
25 the case of Andrew Bilodeau. Your notes with respect
I'm sorry, the typewritten case review with respect



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2 to this child is at page 6. Your conclusion ---

3 Q. Page 6?

4 A. Yes, page 6. I'm sorry, not
5 of the minutes, Doctor, of your bound volumes of
6 case reviews and handwritten notes, I'm sorry.

7 A. Oh.

8 Q. Page 6. Your conclusion again,
9 Doctor, in this case was that there was:

10 "...for the support of natural causes
11 and any suspicion of digitalis toxicity
12 must be very low."

13 At the minutes of the meeting of
14 September 13th you are recorded in the minutes, page
15 21, to have indicated that this child had a progressive
16 downhill course, but you expressed some reservations.
17 You categorized the death in the low suspicious
18 category. This is at page 21 of the minutes, Dr. Fay.

19 Can you help me, Doctor, as to what
20 factor or factors in this case led you to have
21 suspicion as to the involvement of digoxin?

22 A. Well, you know, we are dealing
23 with clinical matters. We are not dealing with the
24 atomic weight of sodium or the speed of light. I
25 am now for the first time discussing this in another
setting and for the first and only time am I



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discussing it with anybody else.

I suppose, and I can't remember, this is the first time I have seen these minutes, that I was swaying very slightly, very slightly. The baby had vomited just prior to the cardiac arrest. The toxicology which, again, I really wasn't in any position to understand, was explained by Mr. Cimbura, the heart 136/236 was said to be within the normal range, the lungs were said to be above average, the liver, upper limit of normal, stomach, large intestines, small intestines, I don't know what they represent, the figures there, and no comment is made.

I think that what I have written here in my final note, the suspicion of digitalis toxicity must be very low, is what I have to say, very low.

Q. I appreciate that, Doctor, and I am grateful for your assistance. I am concerned only if it is today possible on the basis of your recollection or your views today to establish what it is that leads you to have any suspicion at all in this case.

A. Because I am here to explain how I came to make these notes. I mean, this is why I am here, so, I have to explain to you and I am



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2 trying to show that my mind is not rigid about it and
3 I am prepared to alter it but I have no new informa-
4 tion by and large that has been given to me which
5 can make me make a complete turnabout just like that.
6 I have to tell you that I agree and I don't feel
7 very strongly about moving this down to natural
8 causes but you are asking me why at that time I said
9 this and this is the reason I said it. We were
10 looking at it, we were looking at a baby who had
11 received digitalis and we are given some toxicology,
12 which isn't very well understood, and the question
13 comes, could this in this setting have been a
14 possible cause of death and we put it in the low
15 suspicion. There is not much suspicion. These are
16 very soft categorizations. I have nothing new today,
17 I haven't looked at the chart again, I'm going on
18 these notes and I can only say, yes, I would be
19 prepared to say that this was a low suspicion. For
20 instance, if I hadn't had these minutes here and you
21 had had that meeting again and I hadn't seen what I
22 had said before, having occurred 14 months before,
23 I might have given, in this case, a different opinion,
24 I don't know.

25 Q. Well, Doctor, fairly perhaps
I can try it this way. To the best of your



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recollection, was there anything in the clinical course of this child that caused you to be suspicious that digoxin had contributed to his death?

A. Well, the baby vomited just prior to the arrest, the baby arrested.

Q. And that you have told us can be a manifestation of digoxin toxicity, although, equally, it cannot be, in some cases it is not a manifestation.

A. I would think in most cases it isn't and the baby had a truncus arteriosus and children with truncus are very fragile. I can only say that at the time I reviewed it, in the context I was reviewing it, with the group I was reviewing it, I said low suspicion, I still think it is low, I would be prepared to say very low and if you were giving it to me cold I very likely might have put it in the natural causes category.

Q. Doctor, to be fair then, in the clinical course of the child, aside from the vomiting, aside from the anatomical condition, the truncus condition of the child, I take it there was nothing that caused you to be suspicious of digoxin intoxication in this child?

A. No, not really at all; not



1
2 really at all. But we have some toxicology there
3 and it is within the normal range except the lungs
4 are described by Mr. Cimbura as above average, that's
5 all.

6 Q. All right. Doctor, was there
7 anything specific to the terminal events of the
8 child that caused you to be suspicious?

9 A. Well, I told you, the baby
10 vomited prior to the arrest and that's about the
11 size of it.

12 Q. All right, thank you, Doctor.
13 I take it then that in placing this child even now
14 in the low suspicious category, you are having regard
15 then to the discussion by Mr. Cimbura as to the
16 interpretation to be placed on the toxicology digoxin
17 concentrations that he produced at the meeting of
18 September 13th. Do I have that correctly?

19 A. You know, I don't really - I
20 am quite prepared at this point to put this baby into
21 natural causes. I don't feel badly about altering
22 my opinion about it. I am quite prepared to put it
23 into natural causes.

24 Q. Well, Doctor, if there is any
25 confusion in your mind, please understand that I
certainly am not asking you to change your opinion



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one way or another, I am simply trying to understand what it was that caused you to form the opinion in the first instance.

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A. I think it is a question of how low is low. I can only repeat again, you must remember when you question me the context in which I was looking at the charts and the nature of the meeting on September 13th to reach a consensus. If we don't look at it from that point of view I don't feel that it is sensible to examine what I've got here.

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Q. I understand, Doctor, and again I am grateful.

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Could we turn now if you would please to the case of Amber Dawson. Your case conclusion is found at page 11. Your conclusion is that there is no suspicion of digitalis overdosage from the toxicology data and any suspicion of digitalis excess must be very low. Again, Doctor, with respect to this case, having the benefit of your handwritten notes and your case review and your conclusion, can you tell me what it was, Doctor, that led you to have even a very low suspicion in this case?

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25

A. Suspicion at all here.



E11

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2 Well, the baby had very important
3 congenital heart disease and had undergone pulmonary
4 artery banding at a month of age. The baby was
5 receiving digoxin; again, the dosage was in the
6 therapeutic range. The baby vomited the evening
7 before the day of death, the baby had Lasix given
8 the morning of the day that death occurred and the
9 cardiac rhythm preceding the arrest was extreme
10 bradycardia into asystole, that is a standstill.

11 There was no suspicion here from the
12 toxicology point of view. The only thing then that
13 one can say would lead to any suspicion in the
14 context we were looking at was the extreme bradycardia,
15 asystole, the cardiac arrest, that's all. Very, very
16 soft.

17 Q. Doctor, I take it then that
18 it is those two features and that sequence as part
19 of the terminal events of this child that gave you
20 any basis for suspicion.

21 A. That's right.

22 Q. All right. Doctor, I take it
23 from the comments recorded, and just to help you
24 with it, I'm not sure you have to turn to them, at
25 page 17 of the minutes of the September 13th meeting
where you are recorded as having said that you



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observed in this case a very sick child and that
your conclusion was that it was a case of very
low suspicion, that you would have no difficulty
in categorizing this child's disease state as severe
and that she was in fact at the time of her death
very sick.

A. Which page is that?

Q. Page 17, Doctor.

A. Oh, okay.



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The second paragraph at the top
of the page, doctor:

"Dr. Fay referred to his chart and
observed the sick child. He con-
cluded very low suspicion."

A. Yes, very low.

Q. In your opinion, doctor,
in this case, was her disease state severe and
was she, at the time of her death, very sick, as
you indicated at the September 13th meeting?

A. Yes. I haven't included
all that but post operatively, the child had a
paralyzed right diaphragm. I think that is a fair
comment and I think that this could have explained
the death and the arrhythmia at the terminal events.

Q. Doctor, we have heard from
Dr. Rowe with respect to this child as well.

A. Yes.

Q. He testified that her
respiratory problems accounted for some of the
deterioration in her condition prior to her death.

A. Yes.

Q. And that at autopsy perfora-
tions in the stomach were found and they may have
been sufficient to trigger her cardiac arrest.



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Are you in a position, doctor, to indicate whether you agree or disagree with those views?

A. I haven't made a note of any autopsy findings. In fact, I wrote at the top of my original notes, "no autopsy", and somebody has crossed it out. I don't have any autopsy findings here, I don't think. No, I don't. I wasn't aware of that.

Q. Doctor, the autopsy report for this child, as Dr. Rowe indicated, did disclose that perforations in the stomach existed. Dr. Rowe expressed the opinion that having regard to the illness of the child and her condition prior to death, those perforations may have been sufficient to trigger her cardiac arrest.

With that information in hand, doctor, does that influence in any way your conclusion that this child should be placed in the very low suspicious category?

A. Should be placed, in my opinion, in the natural causes, with perforated ulcer or perforated stomach.

Q. Doctor may we turn, if you would please, to the case of Lillian Hoos.

The conclusion for this case is



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set out at page 14. In this case, you indicate:

"The child was on digoxin in suitable dosage and died thirteen days after surgery."

I'm sorry, doctor, this is at page 14. Do you have that?

A. Yes.

Q. "The child was on digoxin in suitable dosage and died thirteen days after surgery. There can be only a very low suspicion that digitalis overdosage was the cause of this child's death."

Once again doctor, with the benefit of your handwritten notes and your case review, can you help us as to what caused you in this case to have any suspicion at all that digoxin was involved in the death of this child?

A. Exactly the same as in several previous cases. A review of the chart in a specific setting with, at 0345 on July 31st, progressive bradycardia and despite intensive attempts at resuscitation, death. Orders for digoxin as usual, as with all the charts I looked at, are within the therapeutic range. The child



Fay
dr.ex. (Cronk)

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was thirteen days post surgery but had severe congenital heart disease. Low suspicion in the setting in which I was reviewing the chart is what I meant by that.

Q. Doctor, you have told us, in the case of Amber Dawson --

A. Yes.

Q. -- the case that we discussed a moment ago, that the extreme bradycardia which she suffered immediately prior to her death leading to complete heart stoppage or standstill, if you will, was in your view grounds for some degree of suspicion, although you put it at low suspicion.

A. Yes.

Q. Was there anything in the case of Lillian Hoos which you perceived to have taken place during the terminal events that caused you to have any suspicion?

A. Apical rate, 40; cardio-pulmonary resuscitation was not successful; progressive bradycardia; the possibility that might have been caused by digitalis; that's all. Very, very low.

Q. I take it doctor, it goes without saying that that kind of droppage in the



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apical rate as well may have been caused by her disease state or any number of other factors not associated with digoxin intoxication?

A. Absolutely.

Q. And similarly in the case of Amber Dawson --

A. Yes.

Q. -- I take it that perhaps goes without saying that extreme bradycardia leading to asystole could as well be caused by any number of factors related to digoxin intoxication; is that correct, doctor?

A. Yes. You have just given me some further very important information about Amber Dawson having perforations of the stomach.

Q. In the case of Lillian Hoos doctor, like some of the others that we have looked at, insofar as I am aware there is no toxicology data which can assist us one way or another with respect to digoxin concentrations in this child?

A. I have none.

Q. Doctor, may we turn then next to the case of Philip Turner. Your conclusion with respect to this child --



1
F6 2 A. Which page is this?
3 Q. It is found at page 16.
4 Do you have that, doctor?
5 A. Yes.
6 Q. You indicate in the last
7 sentence of the next-to-last paragraph:
8 "From the digoxin ordered, the
9 dosage appears to have been quite
10 moderate and the serum digoxin
11 level on July 31st was 0.9 nanograms
12 per millilitre."
13 Stopping there for a moment
14 doctor, I take it we can easily agree that digoxin
15 level as well is within the therapeutic range for
16 infants?
17 A. I can't see it.
18 Q. I'm sorry, the second-last
19 paragraph on page 16.
20 A. Oh, my typed --
21 Q. The second-last paragraph,
22 doctor.
23 A. Yes.
24 Q. The child's digoxin level
25 on July 31st, the day prior to his death was 0.9
nanograms. I can take it we can easily agree that



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is well within the therapeutic range for infants?

A. Oh, that is the low therapeutic range I would say.

Q. And as well doctor, it appears in this case you again checked or at least reviewed the dosage of digoxin that had been prescribed?

A. Yes, I did.

Q. And found them to be adequate?

A. Yes.

Q. Doctor, your conclusion was that death in this case could be attributed to natural causes, but then you then continued and said:

"...there can only be a very low suspicion that digitalis toxicity played any part."

I confess I was somewhat confused; in your mind was the death of this child attributable to natural causes or did you have some suspicion of digoxin involvement?

A. Yes. You see, I think I perceive your difficulty and I think you don't perceive my difficulty. You see, it is very difficult for me, again in the context that I was



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1
2 asled tp review the charts, to know where to
3 balance the severity of the heart disease or the
4 other factors. I don't know whether I am making
5 any headway here. It is very difficult. Of course,
6 most of these children had very severe heart disease
7 and, of course, they could have died. But I am
8 not asked to review their management or the
9 diagnosis or the surgery, or anything of that; I
10 am asked to look from one specific point of view,
11 so it is very difficult for me to know what weight-
12 ing I put on any anatomic diagnosis in the
13 circumstances in which I was asked to do this task.

14 I don't know whether I am making
15 myself clear.

16 You know, just remember the way
17 I entered this investigation. I was asked to look
18 at these charts; we have here four highly sus-
19 picious cases which the police have called murder.
20 That is an entirely different commission to being
21 asked to review the charts and see about the
22 management and so forth, which I wouldn't have
23 accepted anyway.

24 Q. I understand that, doctor.

25 A. It would have been a waste
of my time.

Q. I understand that, doctor.



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A. So having said that, you must bear with me when I express the difficulty I had in always taking into account the seriousness of the heart disease, which of course the majority of these children have - very serious congenital heart disease.

So I would, if given this in another setting, I would have put it into natural causes. But in the setting in which I am looking at it, the terminal events, episodes of sinus bradycardia, arrested; then I at the meeting of September 13th, I agreed low suspicion. Low suspicion, that is what we said. Low, very low. I can't completely rule it out in the setting in which I am looking at this problem.

Q. All right.

Doctor, I am grateful again, and believe me, we do understand the context in which you were asked to take on this task. Nonetheless, we must deal with the fact that, in the September 13th meeting, you are recorded as having placed this child in the low suspicious category but, in the comments which you appear to have made, you suggested that that range might appropriately be from possible to low suspicion. We then come to



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your conclusion in your case review and, on the one hand, you say the death of the infant could be attributed to natural causes; then you go on to say that there could only be very low suspicion.

My question to you quite simply is: Sitting here today, in this context, in this forum, is there anything in the case of this child that causes you to be suspicious as to the possible involvement of digoxin intoxication in his death?

A. Not really, you know. Not really. The child has a severe heart disease and admittedly I don't think one need agonize about changing the categorization to natural causes; it doesn't concern me to change it at this time. I am quite prepared to say this is natural causes.

At the time of the September 13th meeting, taking it all into account in trying to come to a consensus, I put it natural causes and if there is any suspicion, it is very low. I am quite prepared to accept natural causes today.

Q. Doctor, may we turn then to the case of Dion Shrum, if you would.

Your conclusion with respect to this child is at page 21, the bound volume of your



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case reviews. Your conclusion reads:

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"The child was on digoxin in

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moderate dosage but no digoxin

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level was reported. There can

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only be a very low suspicion of

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digitalis toxicity being responsible
for death of this child."

8

Do you see that, doctor?

9

A. Yes.

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Q. It appears once again

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doctor, in this case, that you reviewed both the

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digoxin dosages that had been ordered and reviewed

13

the charts to see if there was any ante mortem

14

digoxin levels that would be of assistance to you.

15

I take it your conclusion was that

16

the doses were moderate, there was nothing

17

suspicious or troublesome about them; is that

18

correct?

A. That is right.

19

Q. Why then in this case

20

doctor, did you entertain any degree of suspicion

21

that digoxin intoxication may have played a part

22

in the child's death?

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A. Because on September 13,

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1982, I was trying to be reasonably consistent,

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Fay
dr.ex. (Cronk)

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just as I am trying to be today. I have only the:

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"...the child became progressively

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more apneic with increasing

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respiratory distress...irregular

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heart rhythm and complete heart

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block.

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Shortly after this cardiopulmonary

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arrest ensued and the child could

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not be resuscitated. The child

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was on digoxin in moderate dosage

but no digoxin level was reported."

12

Certainly severe congenital

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heart disease again but because of the terminal

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arrhythmia, I put it in the low suspicious

category.

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Q. Doctor, may I attempt to

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understand that.

17

In your handwritten notes you have

18

described part of the clinical course of this

19

child.

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A. Yes.

21

Q. And you just referred to it.

22

Was there anything in the clinical course or the

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terminal events themselves that you felt specifi-

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cally gave rise to some degree of suspicion?

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A. No, not really.

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Q. We know doctor, there was
no ante mortem digoxin level to be of assistance
in this case.

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A. Yes.

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Q. Nor was there, as I under-
stand it, any toxicology data.

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A. No.

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Q. Doctor, in the Minutes of
the September 13th meeting, at page 11, in the
discussion concerning Dion Shrum, you are
recorded as having stated:

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"...he would not put this death
in a high possibility category,
but the infant was thought to be
all right upon leaving cardiology;
normal heart rhythm. He did not
think the possibility could be
ruled out."

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I have some difficulty with that,
doctor, as is perhaps obvious. Is it accurately
referred to, "upon leaving cardiology"? What
did you mean by that?

22

A. I don't know.

23

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Q. To help you, doctor, Dr.
Freedom has testified with respect to this child



1
F14 2 that there was, in his mind, some question as to
3 whether or not the child should be admitted to
4 the Intensive Care Unit. The decision was made
5 that that would not take place and the child
6 remained on the cardiac ward and subsequently
7 died in a matter of hours.

8 A. I think that 'cardiology'
9 refers to the Cardiology Catheterization Laboratory,
10 probably, because I have got here:

11 "...left cath lab in stable condi-
12 tion and in sinus rhythm."

13 I suppose that is what is meant
14 by --

15 Q. I would have thought so,
16 doctor.

17 Does the fact of the child's
18 condition after the catheter procedure when
19 coupled with the mode and circumstances of his
20 death cause you any concern or any degree of
21 suspicion in this case?

22 A. Looked at from my vantage
23 point now, not really, no.

24 Q. Doctor, can we turn then
25 to the case of Antonio Velasquez.

A. Yes.



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Q. Your conclusion with respect
to this child is set out at page 31.

Do you have that, doctor?

A. Yes.

Q. You indicate doctor, in
the last three sentences:

"There was a question of an
idiosyncratic response to the
Naloxone. The child was on
digoxin but the digoxin was dis-
continued, according to the notes
on August 20th."

That would be, doctor, some four
days prior to the child's death?

A. Yes.

Q. "The possibility of digitalis
toxicity has to be considered but
the level of suspicion is low in
this case."

Once again doctor, I ask you
what, in your mind gave rise to any degree of
suspicion in this case as to the involvement of
digoxin?



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If I remember correctly there was a question of whether the child had a reaction to the naloxone here. I think that is true; whether the baby had had an idiosyncratic response to naloxone which Dr. Rowe thought would be a very unusual event.

Well, I think only that the terminal event was noted to be cardiac arrest. I am not sure what rhythms were noted if any just prior to that. I don't have any note about that. The child post mortem was congested; findings consistent with some failure I would say.

A. I presume because of a terminal arrhythmia again, that is all.

Q. Doctor, at the September 13th meeting you are reported as having indicated --

A. Where is that?

Q. . I'm sorry, page 19 of the minutes.

You are reported as having said that this child's heart disease was of some magnitude. He was given too much codeine and that you would almost be inclined to put this into the natural category.

A. Yes.

Q. I take it, Doctor, that based



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on your review of the medical record you were of the
view that this child's disease state was most serious?

A. Yes, and as you see from the
voting that is recorded here I am on the lower rung.
All the others are suspicious and I am low suspicious
and I would be quite prepared to put the child into
the natural category.

Q. Doctor, there is in this case
no toxicology data again.

A. No.

Q. Of which I am aware. Is that
correct?

A. Yes, that is correct.

Q. There is no ante mortem
digoxin level four days prior to death which might
be of assistance in determining whether or not
digoxin played any part?

A. Well, exactly. If you had
told me that post mortem blood sample taken
immediately post mortem had given a very, very high
level then I would have had to have changed my
categorization because that is all I had to go on
virtually.

Q. Doctor, you told me much
earlier in our discussion that you had been in



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practice in association with the University Hospital
in Kingston for almost 24 years as I understand?

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A. Yes.

5

Q. In your experience, Doctor,

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in all those years have you ever had a patient
experience what you would term an idiosyncratic
reaction to the drug naloxone?

8

A. No.

9

Q. I take it, Doctor, that it is,

10

however, possible in any individual case that that
could occur?

11

12

A. Oh, yes.

13

Q. Are you in a position, Doctor,

14

based on your review of this child's case to offer
an opinion as to whether or not an idiosyncratic
reaction to that drug in fact in your best opinion
accounts for this child's death?

15

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A. Naloxone was given - I haven't

18

really reviewed the timing of this. Given .2

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milligrams. Improved. Then dosage repeated and

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the baby arrested at 0320. And that was given after

21

0300 so it occurred very shortly after the administra-
tion of naloxone. So I don't think that one could

22

rule out that the baby had an idiosyncratic reaction
to naloxone. I think that is a possibility. As

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3 Dr. Rowe points out it is unusual event but it is
4 a possibility.

5 Q. Doctor, in your best judgment
6 in this case can we in fact rule out digoxin
7 intoxication?

8 A. I would be prepared to
9 recategorize that baby today because the baby had
10 very - certainly very major heart disease and was
11 in - was having problems from the heart disease at
12 the time of death.

13 THE COMMISSIONER: What is natural
14 death that you would recategorize it as? Perhaps
15 that isn't a proper medical question. But you see
16 the problem as I understood from Dr. Rowe's evidence
17 is that they really don't know what caused the
18 death. That is the main suspicion about this
19 child, so when you said it is a natural death what
20 was it? One theory is this naloxone but that is
21 not a universal theory?

22 THE WITNESS: No, it is one possi-
23 bility obviously.

24 MS. CRONK: Q. Could the cardiac
25 condition of this child alone have accounted for its
26 death?

27 A. Well, you know, I am told that



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the baby had tetralogy, had a right Blalock, had probably congestion, pericardial pleural and peritoneal effusions. You know, it doesn't sound to be doing terribly well from the cardiac standpoint.

If Dr. Rowe says he is concerned and presumably has discussed this baby with the staff man who looked after the baby, that makes it difficult, but if you just give me that which is all I had then --

THE COMMISSIONER: Well, there was an autopsy, was there not?

THE WITNESS: Yes, there was an autopsy, anatomic diagnosis.

MS. CRONK: Q. Doctor, perhaps to assist you if I could make this proposal:

Mr. Registrar, could you show the medical record of this child to the Doctor? Exhibit 54. And Mr. Commissioner, with your concurrence I propose that we take our break now.

THE COMMISSIONER: Yes. All right.

MS. CRONK: Q. And, Doctor, I would ask you if you would to review in the medical record over the break page 6 which is a memorandum by Dr. Freedom to Dr. Rowe with respect to this child. And as well, the last several pages



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of the progress notes immediately prior to his death
and I will be glad to point those pages out to you
and we can discuss them with you on our return.

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A. You mean I don't get a break?

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MS. CRONK: Of a different kind.

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Thank you, Mr. Commissioner.

8

THE COMMISSIONER: All right. We
will take 20 minutes.

9

---Short recess.

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--- Upon Resuming.

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MS. CRONK: Dr. Fay, before the break

you were asked by the Commissioner with respect

to Antonio Velasquez, what in that case you felt

could account naturally for that child's death.

Have you now had an opportunity to refresh your

memory on the basis of the record?

A. Yes, yes I have, I have.

There is the question of the naloxone, the narcan,

which is given in high dosage to this child and

we have the opinion of Dr. Conn and the head of

Clinical Pharmacology at the Hospital for Sick

Children that this isn't a toxic effect of the

narcan. However, I still think in terms of when

it was given and when the child died that there

may have been a reaction to the narcan. I know

of no report. I haven't searched the literature

for this. Dr. Rowe says it is a very unusual

event. I think that unless you are prepared, and

I take it from what the Commissioner said, and

I may have misunderstood, Mr. Commissioner, that

Dr. Rowe didn't really think the heart disease

in this child, the death could be attributed directly

to that at that time. I find that a little difficult

to understand because the post mortem, and the child



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2 died three days after the right Blalock, the
3 post mortem shows bilateral pulmonary edema,
4 pulmonary congestion, plus a congestion of the
5 liver, pericardial and pleural and peritoneal
6 infusions, all suggesting to me some degree of
heart failure.

2 7 Q. Well, doctor, to assist you
8 with that if I may, it was indeed Dr. Rowe's evidence
9 in these proceedings that in his view the cardiac
10 condition of the child alone likely would not
11 account for this child's death?

12 A. Would not, yes, okay. Okay,
13 then I think if that is his opinion then I would
14 have to come back to the reaction to naxolone in
15 spite of it not being a toxic action of naloxone
16 and even though it is a very unusual event I would
17 have to think of that as a serious possibility
in the circumstances.

18 Q. I take it, Doctor, from what
19 you have said that you personally have some
20 reservations in concluding that the cardiac condition
21 of the child could not have accounted for his death,
is that correct?

22 A. Yes, I do, I do really. Again,
23 I am not looking after this child in the clinical
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2 setting. I haven't discussed with the cardiologists
3 who looked after the child, I am merely seeing
4 the post mortem findings. All these findings
5 could be evident post mortem and not evident
6 clinically. I mean, the child could have had a
7 degree of congestion which wasn't obvious clinically,
8 pericardial and pleural fluids certainly, that wasn't
9 obvious clinically even on x-ray and a peritoneal
10 infusion, that wasn't evident clinically. That's
11 all a fair statement but there are certainly changes
12 here which suggest some degree of heart failure,
13 even if it wasn't evident clinically, and the
14 baby was somnolent, heart rate came down, the baby
15 was also hypothermic. Well, it had had some codeine
16 of course at that time and that's why the narcan
17 was given. I don't think you could rule out the
18 possibility that this baby died as a result of a
19 reaction to narcan.

18 THE COMMISSIONER: I don't think anybody
19 is doing that, Doctor. I think most people are
20 telling us it is an unlikely cause of death.

20 THE WITNESS: Yes.

21 THE COMMISSIONER: And they also tell
22 us that death from heart disease is unlikely.

23 THE WITNESS: In this instance.

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THE COMMISSIONER: In this instance.

I just wonder, I am not suggesting to you, but when you say, I don't know whether your mandate was to discover whether the child died of digoxin toxicity or to discover the cause of death, but if we change it to the cause of death, isn't digoxin toxicity just as likely as naloxone?

THE WITNESS: Yes, yes it is I think, yes.

THE COMMISSIONER: So that if you say that it is a natural death and you base it upon naloxone and you've got to also say that it is just as likely to be digoxin toxicity, do you not?

THE WITNESS: Yes, it could be. I don't think one can completely rule it out, no.

MS. CRONK: Q. With your permission, Mr. Commissioner, if I may pursue that for a moment.

THE COMMISSIONER: Yes, all right.

MS. CRONK: Q. If in your opinion, Dr. Fay, death from digoxin intoxication is, in this case, every bit as likely as death from an idiosyncratic reaction to the naloxone, what is there in this case that leads you to suggest that digoxin is an alternate explanation for death. What is there in this case that points to digoxin intoxication?



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A. Well, there is nothing very much at all except in the setting in which you see it. You see, I am told that Dr. Rowe didn't think that there was enough cardiac problem to account for the death. I am told that the baby had naloxone and died shortly after that and that was not --

THE COMMISSIONER: Also I think though at one point, I think Dr. Bain told us, I think it is in the chart, is it not, the first time he had naloxone it helped his symptoms?

THE WITNESS: Yes.

THE COMMISSIONER: And the second time, if that theory is correct, it killed him.

THE WITNESS: Three minutes, about, from the second dose, I take it within ...

THE COMMISSIONER: Is that a possibility that one could have the first dose which could assist and then the second dose and then die from it?

THE WITNESS: Well, only if one is talking of a toxic reaction to the naloxone which at that level is not thought by experts in this child to have been sufficient to do that. An idiosyncratic reaction, I would have expected to follow on the first dose.

THE COMMISSIONER: Yes. Well, that is



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2 what Dr. Bain I think said too. But I don't know,
3 this death strikes me at the moment, but like you
4 at the moment I am quite capable of changing my
5 views after a while, to be totally unexplainable.
6 Not totally unexplainable, there are some offered,
7 but no one is prepared to say.

8 THE WITNESS: To say, yes.

9 THE COMMISSIONER: To take a very strong
10 position on the child.

11 MS. CRONK: Q. Doctor, may I add to
12 this as well. It is a fact that in this case it was
13 planned that Antonio Velasquez would be released
14 from hospital and returned to the referring hospital
15 I believe in the West Indies. That was the intent.
16 Shortly thereafter the child had this episode with
17 the naloxone and died. The evidence has been from
18 Dr. Rowe as well that there was in his words no
19 way that he could see that the heart condition
20 could possibly have accounted for this child's
21 death. That evidence, sir, is in Volume 11, page 1915.
22 Dr. Rowe further said that the Hospital for Sick
23 Children never arrived at a confident explanation
24 of the child's death, although, the cardiologist
25 concluded the day after his death that it was, the
greatest possibility was that it was an idiosyncratic



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reaction to the naloxone.

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With those facts in hand, Doctor, is there anything in the terminal events or the course of those terminal events in this child that would lead you today to be suspicious that digoxin intoxication contributed or caused his death?

A. Well, if that is Dr. Rowe's opinion about the status of the child with regard to the cardiac condition, I will accept that. So, that brings us to naloxone or possibly digoxin.



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The child died suddenly, I think we all agree, after a certain injection of Naloxone which isn't given in toxic amounts but is given in large amounts and doesn't respond to resuscitation. If you ask me to take my choice in spite of what has been said I would choose Naloxone.

THE COMMISSIONER: Why does this drug have two names?

THE WITNESS: Well, this is a drug, as you know with regard to drug naming, it is like Lasix is a trade name of the drug company producing it, furosemide is the generic name and we try to stick to generic names.

THE COMMISSIONER: Naloxone is the generic name, is it?

THE WITNESS: Yes, and Narcan is the trade name, I think that's right, yes.

MR. KNAZAN: Mr. Commissioner, I asked Miss Cronk to indicate this and I think she has forgotten.

MS. CRONK: I am sorry.

MR. KNAZAN: I am in the two-dollar seats and when you have a conversation with the witness I can't hear you unless you raise your voice or speak into the microphone.



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THE COMMISSIONER: Yes, all right, I will try to improve. I have said this before, when I am asking a question of the witness I generally haven't the faintest idea what I am talking about and perhaps I would just as soon it wasn't recorded but I never quite get away with that.

How deeply are you affected by the fact that Naloxone was administered and it is in the reports that it was administered? You see one of the theories here is that digoxin was administered to some of these babies, was administered without authority and was not recorded.

THE WITNESS: Yes.

THE COMMISSIONER: Is the fact that there is this reference to Naloxone there, does that sway you one way or the other? If - I suppose there is no way anyone would have suspected Naloxone unless there had been a record of it having been administered.

THE WITNESS: Yes, the child had had some Codeine.

THE COMMISSIONER: Yes, it was feared that the Codeine was causing the damage.

THE WITNESS: Yes. So that if this is correct, the probable dosage was somewhat high as has been pointed out. I think that you are putting



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your finger, Mr. Commissioner, on the point which was difficult reviewing these charts. You know, was the furosemide, furosemide; or, you know, was any drug what it was purported to be and if it was given intravenously just before death, for instance.

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THE COMMISSIONER: Or was there another drug given that wasn't recorded?

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THE WITNESS: Yes, I don't know.

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MS. CRONK: Q. Doctor, you have told us in this case that if you were asked to choose you will choose Naloxone, is that your in mind any more than a flip of a coin?

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A. I don't have anything further to go on than I have been given here. I don't see how I can, apart from taking Dr. Rowe's opinion about the clinical state of the child which is taken, I don't see what I have to go on when you present this to me today other than to suggest the child had a reaction to Naloxone. At the time I considered it, 14 months ago, and I was looking at it, I thought that one could not rule out digoxin completely. I don't think one can rule out digoxin completely today. If you asked me to say what my opinion is now, I think I will choose Naloxone as the cause of death. Now, I don't know what appeared on the death certificate.



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Q. Thank you, Doctor, I understand your position. Doctor, you have told us on a number of occasions, yesterday and again this morning, that the particular mode of death suffered by a number of these children, the terminal events, gave rise in your mind to a suspicion that digoxin toxicity may have been involved in the deaths?

A. Yes.

Q. You have told us for example, that was the case with Amber Dawson, Lillian Hoos.

A. Yes.

Q. You have referred to an event of arrhythmia, including in some instances bradycardia alone and immediately prior to death.

A. Yes.

Q. You referred to the inability to resuscitate a great many of these children. Without suggesting in any way, Doctor, that these events are necessarily indicative of digoxin toxicity, are those kinds of terminal events, that mode of death, nevertheless an unusual mode of death in a population of pediatric patients with congenital heart disease?

A. Not at all, no.

Q. Is there then, Doctor, something



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2 in the suddenness of the onset of these terminal
3 events, or the rapidity of the progress of their
4 course leading to death which in your view is unusual
5 in a pediatric population of congenital heart disease
6 patients?

7 A. Not really, but you must
8 remember the population that I have been handed.

9 Q. Well, the population that I
10 am referring to, Doctor, is the population both of
11 these children that you have reviewed and your own
12 knowledge of pediatric populations; is there anything
13 about the suddenness of the terminal events of these
14 children and the progress of those terminal events
that strikes you as unusual?

15 A. There is nothing, there is
16 nothing that is inconsistent with the serious heart
17 disease which the majority of these children suffered
18 from, all right. Nothing inconsistent in the
arrhythmias of most of them, as far as I am concerned.

19 I am saying again, you must remember
20 the population, and I am being handed a selected
21 population, and I stick to that, this is a selected
22 population, this is not just the population in
23 general. This is, I submit, a very highly selected
24 population of children that I am being asked to look
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at, and any statistician would have to agree with me.

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Q. Doctor, if the selected population was certainly in the sense that all of these children died within a given time frame on the Cardiology Wards 4A/4B at the Hospital for Sick Children.

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A. Yes.

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Q. And in many of these cases as we have seen in the last day and a half, there was, and what you have described as a sudden onset of terminal events.

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A. Yes.

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Q. Characterized or initiated by arrhythmias, in some cases bradycardia and in some cases ventricular fibrillation, and in some cases heart block, the rapid progression of those events leading to an unsuccessful and terminal resuscitation event.

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I ask you, Doctor, with respect to this population when you reviewed them all, all 36, is there anything in those terminal events such as they were, that is sufficiently out of the norm in your view for a pediatric population of congenital heart disease patients so as to cause you concern?

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A. I don't think - I don't think

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3 that if you give me any group that is taken at
4 random that I would have any problem in those
5 cases with regard to the arrhythmia. I don't -
6 except one or two of the children that had normally
7 structured hearts, and you get into the question of
8 Sudden Infant Death Syndrome and so forth, but that
9 is really in the majority of the cases all that one
10 has to go on, the arrhythmias and the death of the
11 child; the brady arrhythmias and the tachy arrhythmias,
12 which can be also a manifestation of digitalis
13 intoxication.
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And this is a population of children that is suspect of having had excess digitalis administered. It is a selected population.

Now the only thing that I have advanced as having swayed me very much in many of the cases which have been gone into the probability category is the toxicology. That is really my - I put those cases in the high probability - that is the extent of the whole survey.

Q . Doctor, fairly of the children that we have discussed this morning we have now discussed some 11, 12 cases ---

A. Yes.

Q. -where you felt there was a possibility of digoxin toxicity involvement in death. In some cases you described that as a very low possibility; in others you simply describe it as a possibility or the case is suspicious?

A. Yes.

Q. You have told us in many of those cases, and I draw your attention specifically to Amber Dawson?

A. Yes.

Q. To Lillian Hoos, that it was the mode of death and the type of terminal events



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J2 2 that caused you in those cases to entertain some
3 suspicion of digoxin involvement?

4 A. That is right.

5 Q. My question to you, Doctor, is
6 this: having regard to the kind of terminal events
7 that these children had, their sudden onset which
8 you described this morning?

9 A. Yes.

10 Q. And the progress of those
11 terminal events without successful resuscitation
12 efforts, are those features in combination such
13 as to cause you a concern regarding digoxin
14 involvement in these cases?

15 A. Well, you know, I thought I
16 had replied to this question. I agree with you
17 that the heart disease in the majority of cases
18 is severe; that this is a mode of death in children
19 with congenital heart disease. I agree with that
20 completely.

21 It is in these cases you have just
22 referred to the only thing I have to go on. It is
23 not diagnostic of digitalis intoxication. It is
24 certainly compatible with digitalis intoxication.

25 You referred to resuscitation.
When you get to cardiac arrest in these situations
whether it be due to drug overdose or whether it



1
2 be due to the natural sequence of severe congenital
3 malformation, then resuscitative efforts are
4 frequently unsuccessful.

5 I think that all I had to go on was
6 a set of charts, and in those charts where the
7 death was shown to be an arrhythmia and I did not
8 see electrocardiographic tracings myself. I don't
9 recall - if I saw them it was only one or two
10 instances. I didn't have the electrocardiographic
11 tracings to see what the rhythm was. It was a
12 description of the rhythm in most cases as I recall
13 that was written down that I took. I didn't look -
14 I didn't see the rhythm strips. And in that setting
15 that is all I have to go on, and therefore it is
16 possible that such a terminal event might be
17 resulting from digitalis toxicity.

18 Q. Doctor, we are left then, are
19 we not, with this situation that in the case of,
20 for example, Amber Dawson, Lillian Hoos, the mode
21 of death of those children and the nature of
22 the terminal events which they suffered gave rise
23 in your mind to some degree of suspicion concerning
24 the involvement of digoxin intoxication, but that
25 would not appear to be the case with children such
as Kelly Monteith, children such as Francis Volk,



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Matthew Lutes who are in your natural causes category.

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Is that not the situation in which
we are left, Doctor?

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A. I think so. I think so, yes.

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Q. For example, that would not
appear to be the situation with respect to Charlon
Gardner which is in your natural causes category?

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A. May I have a look at Charlon
Gardner? Would that be all right?

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Q. Of course.

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A. What page is Charlon Gardner?

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Q. Your typewritten case review
with respect to Charlon Gardner is page 95,
Doctor.

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Do you have that?

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A. Yes.

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Q. You conclude in that case,
Doctor - you described the events:

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"On the fifth day of hospitalization
with the prostaglandin infusion running -"

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A. Yes.

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Q. You indicated:

"... she developed increasing bradycardia,
going into ventricular fibrillation
and did not respond to cardiopulmonary



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"resuscitation."

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Stopping there for a moment, those are events, are they not, that we have seen in other cases over the last day and a half?

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A. That is right.

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Q. All right. You then continued that that diagnosis was confirmed by autopsy.

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"The child was on digoxin but death can be attributed in this case to

natural causes."

A. Yes.

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Q. I suggest to you you concluded in the case of Charlon Gardner where there appears to have been a similar mode of death that her death was attributable to natural causes and in other cases the mode of death of Amber Dawson caused you to have a suspicion, the mode of death of Lillian Hoos caused you to have a suspicion. You have outlined others.

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A. Yes.

Q. Is that not the situation which we are in?

A. You mean the inconsistency? I have got toxicology here on Charlon Gardner.

Q. Yes.

A. And I don't know what all these



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levels mean, but maybe at the time I received them I thought they were high. I don't know, and maybe I didn't think they were.

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I think Mr. Cimbura said that they were within the normal range and I suppose because I had toxicology just as I used it to put some children in the probable category I used this one to put in the normal natural causes.

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Q. I suppose, Doctor -- we heard earlier, of course, that there was toxicology available in the case of Amber Dawson. Did it come down then in your view to the emphasis in any given case which you placed on the toxicology data that was available to you?

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A. Yes, I think it does, and I have already told you that I didn't receive this in my hand in compact form. It came to me in dribs and drabs. Maybe I should have asked for it in compact form to be given the report, but I wasn't given the report, so it's difficult for me now this long time removed to know just how that toxicology in each and every case came to me as information.

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I am not complaining and certainly don't intend to suggest that Mr. Cimbura wasn't



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co-operative, but it wasn't given to me en bloc,
so to speak.

Q. I understand that, Doctor.

Doctor, we have discussed a number
of cases this morning in which you concluded that
there was a very low suspicion of digoxin involvement?

A. Yes.

Q. Apart from the ones we have
discussed as I understand it that was your conclusion
concerning Richard McKeil, Antonio Adamo, Jennifer
Thomas and Michelle Manojlovich. Do I have that
correctly?

A. That was my opinion as stated --

Q. In your case review?

A. In my case report which was
based on the meeting of September 13th, 1982.

Q. And, Doctor, in the balance
of the cases that we have not discussed as I understand
it your conclusion was that the deaths in each
case were attributable to natural causes and you
had no degree of suspicion that digoxin intoxication
played a part in the deaths of those children.
Do I have that correctly?

A. That was the opinion, that was
the consensus that was arrived at, and I would just



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2 say again that with regard to Categories 4 and
3 5 I am quite prepared to say that if you give these
4 to me independently at another time with no names
5 and printed out, and just a very general scenario,
6 I may have put them into 5 instead of 4, and
7 in fact I have done that I think this morning with
8 a couple of them.

8 Q. Are there any, Doctor, where
9 the reverse would be true?

10 A. Well, I suppose since nothing
11 is perfect this side of the Jordan of course I might
12 just do the reverse too, but I don't think so.

13 THE COMMISSIONER: Are there any -
14 unless you are maybe going to be asking this question -
15 but are there any either in 4 or 5 - obviously not
16 in 4, but are there in 5 that you can say, instead
17 of saying just attributing it to natural causes
18 you can say that digoxin intoxication is impossible,
19 or as close to that as medicine can go?

19 THE WITNESS: I think that might be
20 the case. I have reviewed these cases, these cases
21 in here since I received this last week, and I would
22 have to quickly go through them, if you wish to me.

22 THE COMMISSIONER: Well, if you can
23 do it quickly.
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THE WITNESS: Yes, I can do.

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THE COMMISSIONER: I don't necessarily
want you to do it now.

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THE WITNESS: No.

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THE COMMISSIONER: I would just like to
know if there is - if the questions put to you were
not do you think there was digoxin but if the
question were put is it even remotely possible,
now perhaps the Doctor can't answer a question like
that but I think you could probably say that if a
person had a disease that was so terminal that you
would expect it to happen, if a man were run over
by a motorcar I suppose and his life was hanging
by a thread you could reasonably say he did not
die of digoxin overdose.

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Now perhaps you can't say that with
any of these children but if you can it would help.

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THE WITNESS: In Category 5?

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THE COMMISSIONER: Well, I would want to
make it Category 6.

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THE WITNESS: Both 4 and 5.

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THE COMMISSIONER: Category 6. I
don't think there would be any in 4 but if you thought
it was possible then you can't possibly remove them,
but a category where there isn't any sensible rational



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2 conclusion that anybody could reach that that
3 child died of digoxin intoxication?

4 THE WITNESS: I will do that.

5 MS. CRONK: Q. Doctor, I recognize
6 that before providing that information to the
7 Commissioner quite properly you would like to
8 review your conclusion in each of these cases,
9 but so that the record is clear you did have an
10 opportunity before beginning to testify yesterday
11 to review your case reviews and your handwritten
12 notes, did you not?

13 A. Yes, I had a very brief
14 opportunity actually. I was here on Thursday. I
15 went back to work on Friday. I was on duty all
16 weekend and I came here after clinics all day
17 Monday on Monday evening. I didn't have much time,
18 frankly.

19 Q. Doctor, believe me I say that
20 without any criticism. We all recognize the demands
21 on an extremely busy practitioner.

22 My question is simply this: your case
23 reviews and your handwritten notes were provided
24 to you some ten days ago?

25 A. Yes.

Q. And for certainty before you



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began your testimony yesterday you had reviewed them?

A. Well, I wouldn't come here without reviewing them.

Q. Thank you, Doctor.

A. All I am pointing out to you is the fairly short time you have given me to review, and especially something that you gave me last Thursday that refers to a meeting that occurred in September, 1982 which is 14 months ago and which I had never seen before.

I must say again that my time for review was very limited.

Q. And if that placed you in some difficulty Doctor, for the Commission, we regret that.

A. Thank you.

Q. One final question, Doctor, with respect to the meeting of September 13th, it is my understanding and I would ask you whether this accords with your knowledge of the situation, that there was no clinical pharmacologist present at that meeting who participated in the review of these cases. Is that correct?

A. I know that a clinical



1
2 pharmacologist was to be contacted by Dr.
3 Hastreiter. I cannot recall meeting a clinical
4 pharmacologist and I cannot recall a clinical
5 pharmacologist being present at the meeting.

6 I am surprised at the number of names
7 listed as present at that meeting. It certainly
8 was a crowded room. If there was a clinical
9 pharmacologist there I was unaware of it and I
don't think I met him or her.

10 Q. All right. Doctor, quite apart
11 from those who might have been in attendance at
12 that meeting or any other meeting at which the
13 deaths of these children were discussed, did you
14 personally at any time prior to testifying in
15 these proceedings discuss these cases with a
clinical pharmacologist?

16 A. I didn't discuss these cases
17 with anybody. I stated that at the outset.

18 Q. Thank you, sir.

19 A. Not a soul.

20 Q. Thank you very much, sir.

21 I thank you for your co-operation.

22 Those are my questions, Mr. Commissioner.

23 THE COMMISSIONER: Thank you, Miss
24 Cronk.
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2 Mr. Roland? I think there is no one
3 acting - he is not your client? Mr. Brown, are
4 you prepared to proceed?

5 MR. STRATHY: Mr. Commissioner, I am
6 just wondering since the witness was apparently
7 retained by or through the Attorney General's
8 office whether the Attorney General cares to lead
9 off?

10 MR. BROWN: I would go one step further,
11 Mr. Commissioner, and also suggest that the Police
12 since they rely upon this witness, as a consultant,
13 also go before us. I say fairly to you at this point
14 I have no questions. But I think it is a matter
15 of principle that the order should be made.

16 THE COMMISSIONER: I am not too sure
17 which - I would normally take the position that those
18 who are most let's say adversely affected should
19 go last, but the way we have been working things out
20 I don't really know which side this witness is on.
21 So I really can't take a strong stand. But we will ask
22 Ms. Cecchetto. Do you want to go first?

23 MS. CECCHETTO: I would prefer to go
24 in the normal order.

25 THE COMMISSIONER: All right. Have we

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any offers from anybody to proceed?

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MR. YOUNG: I don't mind going first,
Mr. Commissioner. The only thing I might say is
that as in the past should information come to
light later on ---

THE COMMISSIONER: Oh, yes, certainly.
There is no question you will have an opportunity
later on. Within limits.

MR. YOUNG: I am prepared to proceed.

MR. STRATHY: The reason I make the
request, Mr. Commissioner, is really so that all
the witness' evidence in chief is in before we
start our cross-examination.

THE COMMISSIONER: But the difficulty
you see in this case is that this witness is really
not represented by anyone. He is called by the
Commission and I take it you interviewed him without
anyone else being present? Is that right?

MS. CECCHETTO: I was present.

THE COMMISSIONER: Oh, you were present?

MR. STRATHY: He was retained by the
Police or the Attorney General.

THE COMMISSIONER: There may be some
merit in that. There may be some merit in that
position, Ms. Cecchetto. Are you prepared to go on



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now?

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MS. CECCHETTO: Yes, I am.

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THE COMMISSIONER: Well, that solves ---

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MS. CECCHETTO: The only concern I

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have is I know Mr. Brown is going to take the

7

same position with respect to Dr. Kauffman and

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perhaps we would have no complaint with respect

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to Dr. Kauffman but he is also going to take the

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same position with respect to Dr. Hastreiter and we

would like to be heard with respect to those ---

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THE COMMISSIONER: I understand you would

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like to be heard as to whether you should go first.

13

If you go first on this thing you also go last again.

14

You see you get this opportunity so it is not a

totally ill wind.

15

MS. CECCHETTO: All right.

16

THE COMMISSIONER: Yes. All right

17

then Miss Cecchetto.

18

DIRECT EXAMINATION BY MS. CECCHETTO:

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A. Well, Dr. Fay, now I understand

20

there are problems because you have not reviewed -

21

had extensive time to review the material, but in

22

reviewing the minutes of the meeting and in view of

23

the fact that Staff Sergeant Press introducing the

24

meeting indicated the purpose of the meeting was to

25



1
2 categorize the deaths, I put it to you that it is
3 apparent from the minutes and the context of this
4 meeting that the purpose was to determine which
5 deaths were natural and in which deaths there was
6 a question of digoxin having played a part.
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A. That is what I understood.

Q. And I put it to you that it is entirely reasonable, because when you look at Staff Sergeant Press' comments, they were concerned to contact those parents about whose children there was no question whatsoever. He indicates that after this meeting they intend to contact the parents.

A. And I think that point had been raised at a previous meeting at the Police Headquarters.

Q. And in fact if you will turn to page 6 of these Minutes, Doctor, or it is at page 224 if you take the other number. In the case of Kristin Inwood, Mr. Wiley interrupts or interjects and indicates that it is important to reach a consensus because what they are looking at here is a decision as to - not whether or not charges are going to be laid but from the point of view of going to speak to the parents and presenting them with some conclusion. It starts off:

"Staff Sergeant Press expressed the need to present a united front. Mr. Wiley stated that at



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Friday's meeting, the investigative team had been relying on toxicology levels. Dr. Hastreiter observed that one could argue that this was a contaminated sample. J. Wiley asked, when you combine this with the myocardium level, does not this become less likely? Dr. Hastreiter replied, yes, combined with skeletal muscle. Mr. Wiley advised that this decision should not be looked at from the point of view of proving cause of death and going to court; this is to come to some conclusion to discuss with parents."

A. Yes.

Q. And Mr. Young pointed out yesterday, and there will be evidence in the future, as he pointed out, that after this meeting categorizations were reduced to two categories and those children who it was felt was natural death their parents were approached and advised of the fact that there was no question.

A. Reduced to two categories?



Fay
cr.ex. (Cecchetto)

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Q. Yes.

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A. Well, I never heard of that.

4

Q. Well, Mr. Young indicated

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that in yesterday's transcript at page 4777.

6

A. Which transcript?

7

THE COMMISSIONER: No, no, no.

8

MS. CECCHETTO: Q. Of yesterday's

transcript.

9

THE COMMISSIONER: Yes, all right.

10

I think Miss Cecchetto is just making a statement.

11

I think you can agree with that.

12

THE WITNESS: Oh, yes.

13

THE COMMISSIONER: It is the

14

transcript of this proceeding that she is referring to, which you haven't got.

15

THE WITNESS: I see. Okay. Thank

16

you.

17

MS. CECCHETTO: Q. Well, in any

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event, the Minutes very clearly indicate that

19

the parents were going to be advised.

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A. I was just thinking I would

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rather have gone through two categories than four

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because this was the consensus that I keep talking about.

23

Q. Yes.

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MR. ROLAND: And Mr. Young tells us he was sworn as well.

THE COMMISSIONER: He was what?

MR. ROLAND: Sworn.

MR. YOUNG: I wouldn't lie, Mr. Commissioner.

THE COMMISSIONER: No, he always tells the truth.

MR. YOUNG: Thank you.

MS. CECCHETTO: Q. Well now, doctor, you have gone through the various children and it may be that you are prepared to move some children from one category into the next. You have indicated that you might move some who are very low into the natural causes if you were asked but, from the point of view of your mandate in determining whether or not there was any question whatsoever, given the sample of children that you were presented with and given the concern that these parents were going to be approached, was it not your opinion on the 13th that in those categories that you expressed that there was a very low suspicion or unlikely there was some suspicion, perhaps a very negligible question, but some question that diogxin played a part?



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A. That is what I said, yes.

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Q. And, Doctor, is it fair to

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say that, and I think you have already stated

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this, but the only cases that you put in the

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probable cause of death or high suspicion and,

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in fact, in the second category, the good possi-

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bility, are those cases where you had toxicological

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data indicating that digoxin played a part?

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A. I think that's true. I

think that's true.

11

MS. CECCHETTO: Thank you. Those

12

are all my questions.

13

THE COMMISSIONER: Yes. All right.

14

Now, Mr. Brown, are you ready to

proceed? Oh, Mr. Young, all right.

15

MR. YOUNG: As you wish, Mr.

16

Commissioner. I am prepared to proceed.

17

THE COMMISSIONER: No, I don't

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care.

19

MR. BROWN: I would respectfully

request that Mr. Young proceed.

20

MR. YOUNG: I don't want to be

21

difficult, Mr. Commissioner.

22

THE COMMISSIONER: He seems willing

23

to proceed and he is not asking for any conditions,

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25



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K6 2 so that solves our problem.

3 MR. STRATHY: May I speak to my
4 friend for just a moment, Mr. Commissioner?

5 THE COMMISSIONER: Yes, all right.

6 MR. STRATHY: I wonder, Mr.
7 Commissioner, since my friend has made the
8 observation yesterday that the police, subsequent
9 to this meeting, did prepare two lists and I wonder
10 whether he could advise us what the lists indicate
11 insofar as specific children are concerned.

12 THE COMMISSIONER: I suspect the
13 two lists would be natural deaths and suspicious
14 deaths, isn't that right?

15 MR. STRATHY: Well, yes, I am not
16 making myself clear. I would like to know which
17 children are on which list.

18 THE COMMISSIONER: Oh, all right.
19 Can you do that for us?

20 MR. YOUNG: I will do my best,
21 Mr. Commissioner.

22 THE COMMISSIONER: Yes, all right.

23 CROSS-EXAMINATION BY MR. YOUNG:

24 Q. Good morning, Doctor. I
25 think you know that I am one of the lawyers appear-
ing for the Metropolitan Toronto Police at these



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proceedings and my name is David Young.

A. Thank you.

Q. Doctor, I understand that you told us yesterday that you were first contacted by, I believe it was Dr. Bennett.

A. Yes.

Q. In late May or early June.

A. Somewhere around there.

Q. 1982.

A. Yes.

Q. And you were asked to conduct a review of some of these very unfortunate deaths that occurred at the Hospital during the period we are examining; is that right?

A. Yes. Yes, I was. Yes.

Q. Doctor, you later attended at a meeting, the meeting that we have spent a good deal of time discussing, that was September 13, 1982. Do you have any recollection as to how long that meeting lasted?

A. It started in the forenoon, I would think about ten o'clock and we had a break for lunch. I thought it ended mid-afternoon but my memory serves me incorrectly because I have been told that it went on into the late afternoon,



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4:30, 5:00. I can't remember exactly.

3

Q. It was a number of hours?

4

A. Oh, yes.

5

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Q. And when you arrived at this meeting, Doctor, you had already conducted a review of the charts and some other information that was provided to you?

8

A. Oh, yes.

9

Q. Yes.

10

A. Absolutely, yes.

11

12

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Q. And you had, if not a conclusion, some feeling, suspicion, whatever, as to the cause of death of many of these children, perhaps all of the children?

14

A. Yes.

15

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Q. But at this rather lengthy meeting, Doctor, and let's just go over very briefly some of the participants at this meeting.

18

You had Mr. Cimbura.

19

A. Yes.

20

Q. Who was a toxicologist.

21

A. Yes.

22

Q. And I think you told us you knew of his reputation and respected that.

23

A. Yes.

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Q. You had Dr. Hastreiter.

3

A. Yes.

4

Q. And I believe his title
is Pediatric Cardiologist, is that right?

5

A. Yes.

6

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Q. And my understanding is that
he is an expert in the use and effects of digoxin;
he has a lot of knowledge in that area.

8

9

A. It is my understanding he
is one of the most knowledgeable people in that
area.

10

11

12

Q. Thank you, Doctor.

13

Also present was Dr. Bennett.

14

A. Yes.

15

Q. He was, I believe, at that
time the Chief Coroner for Ontario.

16

A. Yes. Yes, he was.

17

Q. And Dr. Tepperman, another
Coroner?

18

19

A. Yes.

20

Q. Dr. Anne Gilmour-Brysen
was present at that meeting as well.

21

A. She was, yes.

22

Q. And Mr. Wiley was there and
he is a Crown Attorney.

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Fay
cr.ex. (Young)

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A. Yes, he was.

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Q. And there were quite a

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number of police officers there.

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A. Yes, Sergeant Press,

6

Sergeant Warr, to my recollection, were there.

7

Q. And at this meeting,

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Doctor, there were these other individuals, and I

9

am speaking mainly of the doctors, because I think

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you told us earlier that most of the discussion

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was not dominated, but most of the time was taken

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up by the medical personnel giving their opinions

13

and discussing the particular cases, I think you

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told us that yesterday. I have the reference of

15

it.

16

A. I would think most of the

17

time was taken up by Dr. Hastreiter with myself

18

and Mr. Cimbura. I think we probably took up the

19

majority of the time for discussion, I think.

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Q. Certainly. And they came

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into the meeting with, in some cases, different

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opinions, different views, different interpreta-

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tions?

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A. Well, I think that was the

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purpose of the meeting. I mean, after all, if that

hadn't been the purpose of the meeting, I suppose



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we could have just submitted a written report and let somebody go through it in a clerical fashion and construct the final opinion from that.

Q. My very point, Doctor. I mean, the very fact you were there was to listen to the other individuals who, in many cases, were experts?

A. Yes.

Q. I don't think there is anything wrong, although I must admit I was getting the inference that there might have been, by being swayed or influenced, for instance, in your own words, being guided by what these other individuals said.

A. Yes. Opinions are the source of opinions, aren't they? So, naturally, in discussing this, and as you can see, I certainly was swayed, if you like. The important thing at the meeting was to come to some agreement. I mean, after all, it had been dragging on for a long time. I suppose I was just as anxious as everybody else to reach a conclusion at that point, and this was the first time that we had all sat down together and talked and discussed the specific cases one by one with the toxicologist present. We had never



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2 done that before.

3 Q. Yes. And Miss Cecchetto
4 just asked you prior to me taking the microphone
5 over here, she asked you the purpose of the
6 meeting and I think you told her that one of the
7 major purposes, if not the sole purpose of that
8 particular meeting, was to reach a conclusion to
9 satisfy some of the parents wherever possible to
reach a consensus; is that correct?

10 A. Well, if you ask me about
11 that specific meeting, I would find it hard to
12 say yes, but I do recall prior to that meeting
13 that at the Police Headquarters concern had
14 been expressed about this matter of informing
15 the parents of some of the children and, therefore,
16 it is completely logical that the decisions and
17 the opinions formulated here and the consensus
18 formed here could form the basis for further
19 information being given to some of the parents.
So, I think that is perfectly reasonable.

20 Q. Well, I think that will be
21 Staff Sergeant 'Press' evidence and various other
individuals.

22 A. Yes.

23 Q. I think we are not disagreeing,
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there is no point in going on with that very point.

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Doctor, at the meeting there was consideration of the overall picture. Would that be fair to say that Dr. Gilmour-Bryson had some input into some of the nurses that might have been present at the time that the children unfortunately died and that there was also information as to describing the terminal events discussed? Was that information discussed?

A. Oh, it wasn't just purely and simply the medical information that came out of that meeting, you know, I wasn't particularly, what shall I say, interested, but you know, there was statistics and compilations of hours and teams and geographic areas and goodness knows what. So, there was some input. I can't give you chapter and verse about it.

Q. And without going into detail about it, did it appear to you, do you recall if there appeared to be some coincidences with respect to those items, the terminal events, the description of them, the nurses that were present, et cetera, et cetera, et cetera?

MR. BROWN: Mr. Commissioner, I object extremely strongly to this line of



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questioning.

THE COMMISSIONER: Well, I think
you are --

MR. BROWN: Well, no, before we
get into that, I have a submission.

THE COMMISSIONER: Yes.

MR. BROWN: On Tuesday, Commission
Counsel distributed to us an unexpurgated version
of the Minutes of the September 13th meeting --
well, perhaps that was on Monday. On Tuesday
morning one of the staff members of the Commission
approached us and asked us to hand back the
unexpurgated version and instead rely upon the
expurgated version. The unexpurgated version
contained information regarding who was on at what
particular time. I think most counsel did not
agree to hand back the unexpurgated version, but
at least I did give an undertaking that I would
not cross-examine on that material.

MR. YOUNG: I gave no such under-
taking.

MR. BROWN: Therefore, I think it
is improper.

THE COMMISSIONER: I don't -- Are
you intending to cross-examine on it?



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MR. YOUNG: No. That was my
last question on that point.

THE COMMISSIONER: You just really
want to see whether it was discussed?

MR. YOUNG: That was my question,
Mr. Commissioner.

THE WITNESS: Well, can I --

THE COMMISSIONER: I think we have
to be a little careful, Doctor.

THE WITNESS: I'm sorry. I'm sorry.

THE COMMISSIONER: Don't go into
detail.

THE WITNESS: No, I won't. No, I
won't at all. Let me go again.

THE COMMISSIONER: Yes.

THE WITNESS: The majority of this
discussion was medical, all right, there is no
question about that.

MR. YOUNG: Q. Yes.

A. The majority of it. I can't
remember in detail all the details of what went
on at the meeting. Now, I had been at meetings
at Police Headquarters. Things other than toxicology
and clinical data were discussed clearly at those
meetings so that I inevitably didn't participate



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in that really, it wasn't anything to do with me, inevitably had a background albeit hazy of geographic areas and names, what have you, I had that. I cannot remember in detail anything of that nature but I have the feeling that some of it was there. I doubt if it was very much at all. I don't want to give the impression that it was. There is no question that the majority of the discussion, the majority of the input was medical, but I can't say that there wasn't any of this. But I had been going to other meetings and it had been discussed, and I think that is as fair as I can be and I think it is as truthful as I can be.

Q. That's fine, Doctor. Would I be correct in saying that you had that information in your mind? I mean, you remembered it from one meeting to another?

A. With any given child that I was looking at here, I might have had a little information about a team, only one or two.

Q. Okay.

A. And in the majority, I couldn't remember, I didn't know anything about the geographic areas, didn't even know where they were.

Q. Doctor, I don't mean to cut



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cr.ex. (Young)

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you off but that was only one of the factors that I suggested might have been considered at the meeting. I think the coincidence, the similarity of some of the terminal events was also something that I thought was discussed at the meeting, and I should tell you if anybody chooses to question the officers about that, that will be their evidence and we certainly will have no hesitation in leading that evidence.

A. Similarity in what?

Q. In the terminal events in that the children seemed -- in fact, we have had Dr. Rowe discussing that.

A. Yes.

Q. The children seemed to die suddenly, bradycardia was present and, without going into detail, there did seem to be some similarity. Are you aware of that?

A. Similarity with what?

Q. I am describing -- go ahead, Mr. Commissioner.

THE COMMISSIONER: I think what he is asking you is, was there at this meeting some discussion of the similarity of the method, the terminal events of death.



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THE WITNESS: Yes, yes. Yes,
all right. Yes, and some discussion I think, a
little, not very much, with regard to time maybe
of the terminal events, yes, I think that's true.



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3 Q. Doctor, the only reason I
4 raise that at this point is that if each case was
5 looked at in a vacuum, in isolation, your conclusions
6 might have been slightly different, in fact they
7 might have been markedly different, would that not
8 be true? Let me add one other factor, Doctor. You
9 approached this meeting, you approached this whole
10 exercise after hearing from Judge Vaneek who said,
11 murder had occurred in the Hospital.

12 A. Yes.

13 Q. And he unlike the Commissioner
14 and myself was allowed to use that term more freely.
15 So you knew that, and I am sure you read the press
16 reports of what had gone on previously. Clearly
17 that influenced you to some extent, even a small
18 extent and that may explain to a small degree why
19 you chose the various categories that you did, would
20 that not be true?

21 A. It has to have some bearing,
22 it has, how much, I don't know; how to weight at this
23 point, at this distance I don't know, but it had to
24 have some bearing. I think I have stated that in
25 as many words this morning, because that is the
avenue through which I approached this review of this
selected population.



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3 Q. Just a few other points. There
4 has been some question about the accuracy of the
5 minutes and you may recall that I stood yesterday,
6 not under oath, but I suggested that I wouldn't swear
7 to the accuracy of each and every word and that the
8 circumstances of the young lady who was taking the
minutes, it was not an ideal situation.

9 Doctor, what I am interested in is
10 your recollection; where the votes are recorded, do
11 you recall that, is that accurate?

12 A. I think so. I am sympathetic
13 with the person who was taking the minutes. There
14 is only one specific instance yesterday which was
15 raised where I thought that I probably might not have
16 said just that, because of my notes, it was at
variance with my notes and I was going on my notes,
for my opinion.

17 Q. While we are on the topic of
18 the minutes, Doctor, page 224 of the minutes when
19 Baby Inwood was being discussed, there is a comment
20 that:

21 "Staff Sergeant Press expressed the
22 need to present a united front."

23 A. Yes.

24 Q. Now, Doctor, did you change
25



1
2 your opinion with respect to this baby as a result
3 of Staff Sergeant Press' comment, did that make you
4 believe that this particular child was probably
5 murdered because he said that?

6 A. Oh, Staff Sergeant Press is
7 a very persuasive person, but I don't think I would
8 have done that just because Staff Sergeant Press said
9 so.

10 Q. Thank you, and when you say
11 he is a persuasive person I think you mean his ---

12 A. His personality.

13 Q. His charm is persuasive?

14 A. Yes.

15 Q. Thank you. Doctor, one last
16 point and I must ask you this, Doctor, because I
17 think that some people may get the wrong impression.
18 I think - let me put it to you this way. I don't
19 think you would have agreed to anything at that
20 meeting that you didn't believe in, is that right?

21 A. No, that is not my style and
22 it is not my philosophy.

23 Q. And Doctor, ---

24 THE COMMISSIONER: I'm sorry, which
25 is not your style?

THE WITNESS: To agree to something



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that I don't believe in.

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THE COMMISSIONER: Okay.

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MR. YOUNG: Thank you,

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Mr. Commssioner.

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Q. And Doctor, did any of the police officers at any time, before, during, or after the meeting induce, coerce, cajole, in any way, in any manner to change your opinion, to change your opinion, to alter your view with respect to these deaths?

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A. No, they didn't. I think it is to their credit, because the police officers were really the only people that I was seeing and talking to on a regular basis, and we didn't get down to discussing that aspect of the deaths at all. Neither did I ever introduce that topic really to them as I can recall. There may, because we were seated in the same room have been an odd remark or two, but all the police officers did was to facilitate the handing over of the charts to me and help me if I was looking for something, that is all, any conversation didn't have to do with the deaths really.

22

MR. YOUNG: Thank you very much, Doctor.

23

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THE COMMISSIONER: All right, thank



1 you. Yes, Mr. Brown, what is your wish?

2 MR. BROWN: Yes, I have a few
3 questions, Mr. Commissioner.

4 THE COMMISSIONER: Yes, all right.

5 MR. KNAZAN: Mr. Commissioner?

6 THE COMMISSIONER: Yes, Mr. Knazan?

7 MR. KNAZAN: Judge Vanek

8 finding murder, and now Mr. Young has referred to
9 it and it is certainly repeated in the paper every
10 few days. I am not sure you are correct in your
11 ruling when you said that he could do that. All he
12 could do is as a Justice sitting at a preliminary
13 hearing is find that there was sufficient evidence
14 on which a jury could find.

15 THE COMMISSIONER: That is what he
16 had to find or not find.

17 MR. KNAZAN: Yes, true in his
18 reasons, which was very complex, he found murder, but
19 maybe we should refer to it more correctly, he
20 really at law was not entitled to find murder.

21 THE COMMISSIONER: Yes, I agree
22 we should. I am not too sure what the correct term
23 is. I am not going to use that word ever, I promise
24 you under any circumstances, here, or there, unless
25 I happen to be involved in something else, something
other than this. I will strike the word right out of



1
2 my vocabulary.

3 Yes, Mr. Young?

4 MR. YOUNG: I am not sure I can
5 promise that, Mr. Commissioner. I am curious, and
6 I hear what Mr. Knazan is saying and I will take that
7 into consideration in the future. I am a little
8 confused as to what we should be calling, what is
9 normally referred to as murder, and if someone can
10 help me, if we want to start calling it intentional
11 overdose of digoxin, it is a little more cumbersome
12 but I can do that.

13 MR. BROWN: Well, Mr. Commissioner,
14 it is one thing to say the child died as a result
15 of an overdose of digoxin, but you yourself have
16 indicated that there are two possibilities that must
17 be considered; one is accidental, and one is
18 intentional. Until this Commission finds as a
19 fact with respect to each child how death was caused,
20 if it was caused by an overdose of digoxin, I don't
21 think the word murder, nor intentional, should be
22 entertained.

23 THE COMMISSIONER: The word murder
24 should not be entertained even if this Commission
25 should find that there was an overdose of digoxin,
either accidental, it should not be, because that



1
2 is not what I am supposed to be doing. I am supposed
3 to be finding out how they came to their deaths.

4 MR. BROWN: Well, Mr. Young's
5 suggestion that intentional would be a proper
6 substitute for murder I suggest ignores the point
7 there is a further point that might be made and that
8 is accidental.

9 MR. YOUNG: I am only suggesting
10 that is how we will describe one possibility,
11 Mr. Commissioner, not that that is the only possibility.

12 THE COMMISSIONER: Well, I think
13 probably at best it is cumbersome even if we find it
14 a little, even if we find being cumbersome a little
15 cumbersome.

16 MR. HUNT: I have a comment on
17 that, Mr. Commissioner. In order to get the full
18 facts from any particular witness, particularly
19 when they are describing something they did at a
20 point in time, we may have to put them back in the
21 context that they were at that time. Now, Judge
22 Vanek was the one who used the word "murder".
23 The press reported it, it was common knowledge to
24 a great number of people at that time that the
25 Provincial Court Judge had found in fact that murder
had occurred.



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3 Now in my submission we shouldn't
4 be playing games with witnesses and changing their
5 terminology.

6 THE COMMISSIONER: No.

7 MR. HUNT: And attempting to
8 describe it as something other than the words used
9 by the judge, if what we are after is their
10 recollection, or their actions at a point in time
11 when that was relevant to them, and this witness
12 has indicated that clearly that it was.

13 THE COMMISSIONER: I think like
14 most things we get into trouble when we try to
15 anticipate what may happen. I think everyone under-
16 stands. My concern is that I am not asked to make
17 that determination, and it would be improper for me
18 to make that determination. Mr. Brown's concern I
19 assume is that we keep throwing the word around and
20 other people start to use it. I just suggest that
21 we use it as little as possible.

22 Now, when we come to the second
23 phase of this investigation I don't see how that
24 word can be avoided. Because, presumably, one of the
25 issues will be whether there were grounds for
suspicion of that particular offence.

MR. HUNT: Well, I agree maybe even



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2 on this phase the word can't be avoided in certain
3 factors, and indeed if I or anyone else chooses to
4 ask a witness about murder I really can't see that
5 the fact that Mr. Brown objects to that or anybody
6 else objects to it is a basis to really request us
7 to soften it down in any way.

8 THE COMMISSIONER: All right, I
9 have made my own promise, I will not be using the
10 term; Mr. Brown will not be using the term; other
11 people may attempt to use the term and we will just
12 have to face it at the time.

13 MR. BROWN: I think at this point,
14 Mr. Commissioner, the point should be addressed.
15 The Attorney General I think is acting under a
16 misapprehension that this is akin to Court of
17 Criminal Jurisdiction.

18 THE COMMISSIONER: No, but just
19 to give an example; for instance, it would be very
20 difficult to go through this Exhibit 261 examining
21 anyone without using that word, because it is used
22 so often throughout that it would be impossible.
23 I agree with you that where we can we should avoid it.

24 MR. BROWN: The point of the
25 questions to persons with respect to their conduct
at a particular point in time, I submit it should be



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2 made clear to the Attorney General that this Public
3 Inquiry does not have jurisdiction to determine
4 intent and you yourself have made that clear.

5 THE COMMISSIONER: Yes.

6 MR. BROWN: Without that jurisdiction
7 that governs the relevance of the evidence and the
8 questions that can be put to the witness. I would
9 suggest that the Attorney General should be made
10 abundantly clear that this is not a preliminary
11 inquiry, nor is it a trial and he should govern
himself accordingly.

12 THE COMMISSIONER: I think he under-
13 stands.

14 MR. HUNT: I think my friend, for
15 his assistance, with great respect, if the witness
16 is of the opinion that a particular baby was murdered,
17 and I know that I intend to ask the witness that,
18 whether or not it suits my friend or not, and it
19 seems to me that is something that you would be
interested in as well.

20 THE COMMISSIONER: Well, I am not
21 interested in whether the baby was murdered. I am
22 interested in whether the baby died of an overdose
23 of digoxin, whether that overdose was accidentally
24 or intentionally administered but that is as far as
25



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2 it goes. When I say intentionally, I mean without
3 consciously administering it, that is really as far
4 as I can go. It really doesn't help me if a witness
5 is of the belief that some baby was murdered, because
6 that I can't express an opinion on, therefore I am
7 really not interested in hearing about that from the
8 witness.

9 THE COMMISSIONER: All I want to
10 know, and I think the question is: Could this baby
11 have died of an overdose of digoxin? Do you believe
12 that he did die of an overdose of digoxin? Do you
13 believe that that overdose could have been accidentally
14 administered? Or was it more likely to have been
15 intentionally administered? All of those questions
16 are legitimate. When you go the further step and
17 say, was it murder, you and I both know that that
18 is a legal term and that is something that I am not
19 to determine.

20 MR. KNAZAN: I don't dispute you
21 have to deal within the mandate that you have been
22 given and the rules that you make, but it may be that
23 a witness chooses to express his or her opinion in
24 a particular way. If the witness feels that a great
25 quantity of vials were opened in order to provide
the amount of digoxin necessary and they choose to



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2 express themselves in those terms, then I say we
3 have to separate what evidence comes and what you
4 do with it, and in separating those that we, because
5 Mr. Brown doesn't like it, ought not to be restricted
6 to pose the questions in the way that suits him.

7 THE COMMISSIONER: Well I am not
8 doing it just because Mr. Brown doesn't like it. I
9 am really doing it because it doesn't help me, and
10 if doesn't help me, if it doesn't help the Commission
11 I don't really see why we have to have that. However,
12 let's wait, let's wait and see what happens.

13 I think if you could so conduct
14 your cross-examination that you won't use the word,
15 if the witness does use the word along the line that
16 is something that you probably can't control and it
17 won't have much effect on me.

18 Now, has that, have we talked ourselves
19 into, not quite into one o'clock, who is coming on?
20 Oh, Mr. Olah.

21 MR. OLAH: I have a problem, I was
22 hoping if we had a few minutes I could address you,
23 sir.

24 THE COMMISSIONER: Yes, all right.
25 Were you planning to be some place else this afternoon,
Mr. Brown?



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MR. BROWN: No.

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MS. KITELY: Mr. Commissioner, if
my friend is going to make submissions could Dr. Fay
come off the witness stand?

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THE COMMISSIONER: Yes, certainly.
You are going to talk for at least five minutes, are
you?

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MR. OLAH: I don't know,
Mr. Commissioner, I am as much in your hands as
usual.

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THE COMMISSIONER: Yes, we start
again at 2:30 and if you would like to excuse yourself,
Doctor.

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MS. CRONK: Thank you, Doctor.
---Witness is excused.

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2L/DM/ak

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2 MR. OLAH: Mr. Commissioner, I have
3 had an opportunity to read your remarks of
4 yesterday, and upon considering it fully I am left
5 somewhat in the dark and I was hoping you could
6 assist me this morning.

7 The problem I have got is simply this,
8 sir. As you noted in your comments yesterday, at
9 an earlier time you indicated to all counsel, and I
10 quote:

11 "I cannot imagine that there could ever
12 have been the slightest doubt as to
13 why each member of the Trayner team
14 is here represented by Counsel funded
15 by the Province."

16 And you went on to indicate:

17 "Each of them may be found to be
18 implicated either by accident or with
19 deliberation in the deaths of the
20 children."

21 Yesterday you seemed to suggest that
22 some members of the Trayner team may or may not
23 receive notice in the future under Section 5(2).

24 The contradiction I am left with, and
25 this is where I am seeking your guidance, sir, and
it is plain and simply this; I would like to know



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whether this Commission has, pursuant to Section 5(2)
of the Public Inquiries Act given notice to my
client Janet Brownless.

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THE COMMISSIONER: Do you want an
honest answer to that? I don't know, I don't know,
I don't know, because I don't know whether any notice
is necessary to her at all, I don't know what the
evidence is going to be.

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MR. OLAH: I understand your dilemma,
sir.

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THE COMMISSIONER: I say your
motion is premature because it can only be appropriate
at the precise moment when I reach the conclusion,
if I have reached the conclusion that I have got to
say something in the report that is adverse to her.

MR. OLAH: I understand that position.
What I would like to know is that as of today, as of
this moment, can I then consider that my client
Janet Brownless has not received notice under Section
5(2)?



M/EMT/ak

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3 THE COMMISSIONER: I am not in the
4 witness stand. I don't have to answer and I will not
5 answer that question. She may have received it and
6 she may not have. It is not a problem now and it
7 doesn't become a problem until I - I will tell you
8 now this if it is of any assistance to you: I have
9 no present intention of making any adverse comments
10 upon your client.

11 MR. OLAH: I understand that.

12 THE COMMISSIONER: I have no present
13 intention. I don't make any promises about the future.

14 MR. OLAH: I understand that also,
15 but you have to appreciate the difficulty I face and
16 my client faces.

17 THE COMMISSIONER: I know.

18 MR. OLAH: And this is why I am
19 trying to understand what I am facing.

20 THE COMMISSIONER: Yes.

21 MR. OLAH: Because I am trying to
22 determine whether I am still only an interested
23 party under Section 5(1) or whether you are consider-
24 ing me a Section 5(2) party who is now under notice
25 and I don't understand as of today which category I
fall in.

All I am seeking is guidance from you,



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3 sir, as to whether or not I have had notice so
4 that I am a Section 5(2) party or whether I am a
5 Section 5(1) party.

6 THE COMMISSIONER: All right. The
7 great advantage of being a judge is that you are not
8 allowed to speak to anybody after you have given the
9 judgment. The only person, the only people that you
10 should speak to if you are dissatisfied is the Court
11 of Appeal. You shouldn't ask me necessarily, unless
12 there is something about this thing that is - that
13 what I have said is unclear, and even under those
14 circumstances if something is unclear you have to
15 take your remedy elsewhere.

16 I have tried desperately to make my
17 position clear, and I obviously have not succeeded.
18 I am not going to try again.

19 MR. OLAH: I am truly sorry, but I
20 really had difficulties understanding the position.
21 I understand your final position and I will leave it
22 at that.

23 THE COMMISSIONER: Yes. All right.

24 MR. OLAH: Thank you.

25 THE COMMISSIONER: All right, thank
you.

That has worked us up now to one o'clock



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so unless you want to say you have no - anyway there
is no witness to say it to so we will come back at
2:30.

---Luncheon recess.



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--- on resuming at 2:30 p.m.

THE COMMISSIONER: Yes, Mr. Brown,
now.

Doctor, you always seem to be
left with problems to work out. Do you have any
answers you want to give us further or not? You
don't need to; I just thought you might have.

THE WITNESS: No. No, I have no
pressing problems that I am experiencing.

THE COMMISSIONER: All right.

THE WITNESS: I may have later.

THE COMMISSIONER: All right.

CROSS-EXAMINATION BY MR. BROWN:

Q. Dr. Fay, my name is Brown
and I act for Nurse Susan Nelles.

Through the course of your testi-
mony you have indicated to us you were retained in
this matter to conduct a very specific review of the
medical charts, in particular the role if any that
digoxin would play in the death of these children.

I believe you have also stated to
us that when you went to the meeting on September
13th it was your understanding that the purpose of
that meeting was to reach a consensus as to whether
or not and to what extent digoxin played a role in



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the deaths of these children. Is that correct?

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A. Yes. Yes.

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Q. And during the course of

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that meeting I believe four categories were used to

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assist you in that exercise. That is, if you would

7

refer if you wish to the first page of the Minutes

8

of the meeting on September 13th, there is a

9

category of murder; there was a second category of

10

probable murder and a third category of suspicious

11

A. Yes. There were other

12

classifications talked about at the same time which

13

appear on the second page; that is Dr. Hastreiter's

14

good, fair and small, corresponding with A, B and C.

15

Q. That is quite correct. When

16

it came to the vote, however, you voted according to

17

those four categories that I put to you?

18

A. Yes, that is true, yes.

19

Q. And we have been advised by

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Mr. Young and I believe we have also been advised by

21

Miss Cecchetto after this exercise was performed on

22

September 13th these four categories were collapsed

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into essentially two categories: those deaths in

24

which the cause of death could be attributed to

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natural causes and all the others.



Fay
cr.ex. (Brown)

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Is that your understanding?

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A. Well it is my understanding

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today. I didn't put them into two categories. When

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I dictated my notes sometime after that meeting I

6

used the grading that we had agreed on that day, and

7

I didn't know that they had been collapsed into two

8

categories, but I can see it would be fairly simple

9

to do that even with the categories I have here,

10

if you like.

11

Q. I appreciate that and we

have really just been informed of that today.

12

A. Yes.

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Q. By Mr. Young.

14

A. Yes.

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Q. I understand that today

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we were also informed that the purpose for collapsing

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these deaths into two categories was that those

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deaths which fell within the ambit of natural cause

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the police would then be able to contact the parents

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and assure them that nothing untoward has happened

to their children while they were at the Hospital.

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Is that your understanding?

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A. Well, I can't remember that

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specifically being brought out on the 13th, but I

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can certainly remember that being discussed at some

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AA4 2 length. I presume that must have been and I don't
3 know but I can think that must have been at the
4 meeting at Police Headquarters preceding that
5 September 13th meeting I think.
6 Q. Yes.
7 A. It certainly was discussed.
8 Q. That is right and we have
9 been advised by Mr. Young that that is in fact what
10 happened.
11 A. Yes.
12 Q. If I could turn you to page
13 4 of the Minutes of the meeting -- well, either page
14 222 or page 4.
15 A. Yes.
16 Q. I would draw your attention
17 once again to the case of Baby Inwood.
18 A. Yes. Baby Inwood, yes.
19 Q. Miss Cronk has already ex-
20 amined you on this child to some extent. I'm sorry,
21 at great length in fact.
22 A. Yes.
23 Q. I refer you to the second
24 full paragraph, and in that paragraph it states that
25 you would not rule out the possibility of the involve-
ment of digoxin toxicity but you did not think it was



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very likely and therefore you would place the death
in the low suspicious category.

A. That is right, yes.

Q. And then if I may direct
your attention to the paragraph following there is
a report by Mr. Cimbura on the toxicological tests
that were conducted, and he made reference to findings
of digoxin in heart tissue, in skeletal muscle, in
what is reported to be a serum sample and also a
specimen of blood which apparently was obtained
ante mortem.

A. Yes.

Q. And in the final paragraph
on that page he reviews to some extent his opinion
and concerns with each one of those findings.

A. Yes.

Q. And indeed his discussion
continues on over onto the top of page 5 and Mr.
Cimbura then apparently stated that it was his
opinion that with respect to digoxin toxicity that
conclusion might be inconclusive because of lack of
good specimens of blood or serum, and you would agree
with me that that is what appears to have been
recorded --

A. Yes.



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Q. -- in the Minutes of this meeting?

A. Yes.

Q. Obviously there were other concerns about the samples which were taken and indeed in the subsequent paragraph on page 5 Sgt. Warr discusses the origin or source of these serum samples and goes into detail about the storage, possible heating and the apparently frozen condition.

Dr. Hastreiter then makes a comment on the significance of the fact that this sample was heated, and you would agree with me that it appears to be what was reported as having been discussed in that meeting?

A. Yes, that is right. I am not sure right now that I understand quite what Dr. Hastreiter's comment means now, not from the Minutes. I presume he means that he did not think heating the serum --

Q. Would have much --

A. -- would significantly affect it.

Q. Would significantly affect it?

A. I suppose so, yes.



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Q. But it does appear at that time the storage of the sample and the effect of heating was canvassed.

A. Yes. It was canvassed?

Q. It was canvassed by both Sgt. Warr and Dr. Hastreiter.

A. I am not sure what you mean right there because it wouldn't be much use canvassing me about some of these toxicological --

Q. I'm sorry.

A. That is not in my field at all.

Q. But it was discussed by Sgt. Warr?

A. Yes, sure.

Q. And also by Dr. Hastreiter?

A. Oh, yes, sure.

Q. If I then might direct you to the full paragraph just before the vote Dr. Hastreiter states that he agrees with you that the child was very sick and one could strongly argue that the death could have been natural on the basis of the type of disease; the death, however, was somewhat unexpected.

Dr. Hastreiter apparently said that



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2 everything hinges on the toxicological findings. He
3 observed that we do not know what this specimen is,
4 although it is the highest reported for anybody. He
5 then makes a comment that if he were a defence lawyer
6 he would say this might have been a contaminated
7 sample.

8 On the other hand at that point he
9 seems to state that the fixed myocardium specimen
10 is a high level and also that the level in the skeletal
11 muscle is considerably higher than he has found in
12 therapeutic situations. And you would agree with me
13 that that appears to have been the matters discussed
14 by Dr. Hastreiter at that time prior to the vote?

15 A. Yes.

16 Q. So that prior to the initial
17 vote, doctor, would you agree with me that there was
18 a discussion by Dr. Cimbura about the toxicological
19 findings that had been made?

20 A. Yes.

21 Q. And there had been a comment
22 by Sgt. Warr as to how the specimen had been stored?

23 A. Yes.

24 Q. There was a comment by Dr.
25 Hastreiter on the effect of that storage on the,
one might say, accuracy or validity of that reading?



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A. Yes.

Q. There was then a discussion by Dr. Hastreiter about the clinical and anatomical condition of the child, and he appears to have agreed with you that the child was quite ill?

A. Yes. Yes, he does.

Q. And again before the vote Dr. Hastreiter raises the possibility of contamination of sample?

A. Yes.

Q. At the same time he states that the myocardium levels are high and that the skeletal muscles were high.

If we are to rely on the accuracy of these Minutes as to what was said at that particular point in time you would agree with me that all those matters were raised before the first vote, wouldn't you, Dr. Fay?

A. Yes. Yes, they were.

Q. After reviewing the clinical evidence, the anatomical evidence and the toxicological evidence, a vote was then taken.

MR. YOUNG: Excuse me, Mr. Commissioner. I apologize for interrupting my friend but he has twice now put a number of pieces of information to



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the witness. Indeed that was discussed at the meeting and the witness has agreed but unless I am missing something there seem to be two areas that were also noted in the Minutes that were discussed prior to that first vote that my friend hasn't put to the witness.

I think to be fair there is one paragraph and part of it is just blocked out and I can't read the whole thing but it appears that Dr. Bryson reported on the time periods for the onset of critical symptoms and death, and then later on it appears that Staff Sgt. Wolfe referred to cards and reported nurses on duty.

I think to be fair all of that should be put to him and then the vote discussed.



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MR. BROWN: Well, I have no difficulty with that. It does appear, although the copy that we have has been expurgated, that there was information given as to the time and the symptoms of death and that there was information given as to the nurses who were on duty, that is apparent from the face of the minutes, is it not, Dr. Fay?

A. Oh, yes, but I can't remember what was said at that time.

Q. And I would take it that when you were reviewing the evidence and then preparing to cast your vote, as a doctor, your vote would be cast primarily on the basis of the clinical, anatomical and toxicological evidence that had been put before you, is that correct?

A. Yes, yes, that was exactly, that was all I could base my opinion on, really.

Q. We then come to the first vote which was taken. Dr. Hastreiter appears to have cast the vote of suspicious death and he makes a comment at that time:

"Not placing much weight on toxicology analysis since it is not known where the serum came from."

A. Yes.



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Q. That appears to be his primary concern, does it not?

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A. Yes, yes, yes it does.

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Q. You then cast your vote, ranked it as a low suspicion, and you comment:

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"Would rule out the possibility of overdose. It would be difficult to be absolutely convincing from the toxicology analysis."

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I take it that your reference there to the toxicology analysis referred to the discussion by Mr. Cimbura of the measurements, the discussion by Sergeant Warr of the storage of the sample and the discussion by Dr. Hastreiter of the effect of that storage and the levels found in the myocardium specimen and in the skeletal muscle specimen, would that be accurate?

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A. Correct, yes.

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Q. Dr. Bennett casts a vote of suspicious death, Dr. Tepperman then casts a vote of suspicious death, Mr. Cimbura casts a vote of suspicious death and Dr. Gilmour-Bryson casts a vote of suspicious death. I understand that Dr. Gilmour-Bryson does not have a medical background and was there for another reason. But dealing with



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2 the four medical doctors, you appear to be unanimous
3 that the category that you would place this death
4 in is suspicious, although, there were differences
5 in shade, shall I say?

6 A. Yes.

7 Q. But you did not put it in
8 murder?

9 A. No.

10 Q. You did not put it in probable
11 murder?

12 A. No.

13 Q. And you did not put it in
14 natural causes?

15 A. No.

16 Q. Mr. Cimbura, the toxicologist,
17 cast a vote similar to yours, he placed it in that
18 third category, suspicious death?

19 A. That's right.

20 Q. Dr. Fay, if the purpose of
21 this meeting was to reach a consensus as to the
22 role of digoxin in the deaths of these children,
23 would you agree with me that it appears from that
24 vote that the medical doctors, the toxicologist
25 and Dr. Gilmour-Bryson cast a vote for the same
category, that is, suspicious death?



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A. Yes, at that point a consensus has been reached.

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Q. So, there is unanimity amongst the medical people, with the toxicologist and with Dr. Gilmour-Bryson?

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A. Yes.

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Q. And we have subsequently been advised by Mr. Young and perhaps by Miss Cecchetto that one of the other purposes of this meeting was that the police would use the results of the meeting, rank the deaths according to natural cause or not natural cause and then approach the parents of those children whose death did fall into the category of natural cause. That appears to be our present understanding.

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A. That the parents of the children ...

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Q. Whose death according to the consensus could be attributed to natural causes?

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A. Yes, yes.

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Q. Well, would you agree with me that if that was the use to which this vote would be put by the police, that on the face of that vote there is unanimity amongst the experts that the death was not attributable to natural causes?



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2 MR. HUNT: Mr. Commissioner, could I
3 just draw something to your attention. The evidence
4 at this point hasn't suggested that the purpose of
5 this meeting was to have unanimity amongst the
6 experts only, being the medical experts. The
7 police were represented there and Sergeant Warr
8 indicated at the end of each vote what the position
9 of the Homicide Department of the Police Force was
10 and at that point in time when the first vote was
11 taken, while there was suspicious death indicated
12 as a unanimous choice amongst the experts, the
13 Homicide team had voted unanimously, that is
14 representing one vote representing a number of
15 opinions, that this was probably murder. So, it is
16 really inaccurate to suggest at this point in time
17 there was unanimity in the context of the unanimity
18 that was being sought at this meeting and whereas
19 the police are the ones who had to go and deal with
20 the parents, having come to the conclusion that
21 was probably murder, it is very difficult for them
22 at this point to treat this vote as one that has
23 resulted in a unanimous opinion.

24 THE COMMISSIONER: I don't know what
25 happened but did not the police, the approach to the
parents was only to tell them whether it was natural



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death or not, am I right?

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MR. HUNT: After the votes were taken
and they come to a unanimous decision.

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THE COMMISSIONER: Yes. Well, I don't
know, I don't know whether they had this view
before but there was unanimity that it was not a
natural death.

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MR. HUNT: Well, there was unanimity
in that it was not a natural death. There was
unanimity in that sense that it was not a natural
death, but in terms of ----

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THE COMMISSIONER: Of the categories,
no.

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MR. HUNT: I think what you will
eventually hear is that it was very easy to deal
with deaths where everyone is in agreement they are
natural but the parents of the children whose
deaths were not natural deaths also had to be
spoken to and in terms of giving them the best
position of investigators, that's why there was
a need for a gradation of suspicion in other words.
So, that is the point I raise.

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MR. BROWN: Well, Mr. Hunt has really
anticipated the questions that I propose to put to



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the witness. We will be most interested to hear from the other participants of that meeting at a later time as to the purpose and the conduct of the meeting.

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THE COMMISSIONER: Yes. I just want to ask Mr. Hunt a question now. You don't need to answer it. After this meeting I take it that the police didn't go to the parents, is that right?

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MR. HUNT: Perhaps Mr. Young can answer that.

MR. YOUNG: I believe that is correct, Mr. Commissioner.

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THE COMMISSIONER: And again you don't need to answer this question if you don't want to but did they go to all of the parents or just to those ----

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MR. YOUNG: I can only give you my understanding and that is that they did speak to all of the parents and it took some time and they sat down and discussed this matter fully with each and every set of parents and I will give you more information on that.

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THE COMMISSIONER: It wasn't just the natural death parents?

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MR. YOUNG: Well, no. I suspect in the



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2 cases - the only parents that were given a conclusion
3 as to the cause of death would be those parents
4 whose children had died as a result of natural
5 causes.

6 THE COMMISSIONER: It was probably the
7 conclusion that we all heard about that there were
8 so many that were deleted from the ... Yes, Mr.
9 Shinehoft.

10 MR. SHINEHOFT: All I can say, just
11 following up on what Mr. Young has to say is that
12 my parents, the people that I represent, were
13 certainly contacted by the police and there was
14 some discussion as to what happened as far as their
15 child is concerned. I am not speaking for all the
16 parents, but certainly as far as the people I
17 represent.

18 THE COMMISSIONER: Yes. Yes, all right,
19 Mr. Brown.

20 MR. BROWN: Q. Yes, Dr. Fay, Mr.
21 Young anticipated - I am sorry, Mr. Hunt anticipated
22 some of the questions I was intending to ask you.

23 If I might just draw you back to the
24 last question that I asked. I asked whether after
25 the first vote there appeared to be unanimity or
agreement amongst the medical experts, the toxicologist



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2 and Dr. Gilmour-Bryson as to the category in which
3 the Inwood death should be placed?

4 A. Yes.

5 Q. And I believe you said yes,
6 yes, that's correct?

7 A. Low suspicion I said, yes.

8 THE COMMISSIONER: Suspicion, low and
9 just straight suspicion. You are the low suspicion
10 and others were the suspicion?

11 THE WITNESS: Yes, right.

12 THE COMMISSIONER: But that is all
13 the same category, so, you are quite right it was
14 the same category.

15 THE WITNESS: Yes, sure.

16 MR. BROWN: Q. And then after the vote
17 had been taken it is reported that Sergeant Warr
18 stated that the unanimous opinion of the Homicide
19 team had then probable murder, which would have
20 been the category above. So, there appeared to be
21 agreement amongst the medical experts and the
22 toxicologist and Dr. Gilmour-Bryson but there was
23 not agreement between their opinion and that of
24 the Homicide Squad. Was it one of the purposes
25 of this meeting that there be agreement amongst
everyone, both the experts, the medical experts and



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2 the Homicide Squad as to the category in which each
3 child was to be placed in respect of the role of
4 digoxin in his or her death?

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5 I am not certain that I can answer
6 that unequivocally. I wish I could. I would have
7 said, you know, at this time interval I thought
8 that this was probably not the case but I think,
9 looking at these minutes, that that in fact must
10 have been the case, they were seeking unanimity
11 from the whole group. But if you had asked me
12 that without referring to this, I think I would
13 have answered differently. So, I am sorry, I can't
14 be absolutely clear on that point.

13 Q. Well, I can quite understand
14 the difficulties of 14 months. It would then, you
15 would agree with me, appear from the face of the
16 minutes, however, that after a vote by the
17 medical experts and revelation of the vote by the
18 Homicide Squad there was a difference and would
19 you agree with me that it was that difference
20 that appeared to precipitate further discussion
21 of the classification of the Inwood child?

21 A. Well, certainly it took place
22 after that, yes.

23 Q. And indeed if we turn to the
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2 next page of the minutes, page 224 or page 6,
3 Staff Sergeant Press expressed the need to present
4 a united front, and I believe yesterday you said
5 you really couldn't recall what that meant. Looking
6 at it from the point of view today, would it be
7 a fair interpretation that the united front would
8 be an agreement of opinion amongst the medical
9 experts, Mr. Cimbura, Dr. Gilmour-Bryson and the
members of the Homicide Squad.

10 A. Yes. I suppose from the
11 point of view of identifying and deciding and
12 acting on a group whose parents needed - in the
13 opinion of all I think it is fair to say - to
14 be given some information one way or the other,
15 yes.

16 Q. Then there is a reference which
17 Miss Cecchetto brought out to a point made by Mr.
18 Wiley and that is contained in the first full
paragraph on page 6 about five or six lines down.

19 "Mr. Wiley advised that this decision
20 should not be looked at from the
21 point of view of proving cause of
22 death and going to court; this is
23 to come to some conclusion to discuss
24 with the parents."
25



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2 However, that is not to suggest to you,
3 Dr. Fay, is it, that with that object in mind you
4 would have been any less careful in your analysis
5 of these children to determine the role digoxin
6 may have played in their death?

7 A. No.

8 Q. And whether it was the purpose
9 to advise the parents?

10 A. Yes.

11 Q. Or whether it was the purpose
12 to prove the role of digoxin in their deaths, the
13 accuracy and the time that you spent on the analysis,
14 I take it would be the same, would it not?

15 A. Yes.

16 Q. There was then a second vote
17 taken and the results appear at the bottom of the
18 page. As a result of that second vote the three
19 of your colleagues and yourself changed your vote
20 to probable murder and Mr. Cimbura changed his vote
21 to probable murder and Dr. Gilmour-Bryson changed
22 her vote to probable murder. I think Miss Cronk
23 asked you this question yesterday but in view of
24 the discussion by Mr. Cimbura before the first
25 vote, in view of Sergeant Warr's statements as
to the origin of the sample, in view of Dr. Hastreiter's



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2 comments on the effect that storage might have on
3 the sample, and in view of Dr. Hastreiter's
4 comments on the level of digoxin in the skeletal
5 muscle and in the myocardium tissue, what new
6 piece of information made you, three of your
7 medical colleagues, renowned toxicologists and
8 Dr. Gilmour-Bryson change their votes?

9 A. Well, as far as I can state
10 from my point of view and speaking for my change
11 of vote it can only have to do with discussion
12 that took place after the first vote. I don't
13 know whether all of that discussion is contained
14 here, I presume that the most important aspects
15 of that discussion are in fact contained here and
16 I think that you see a change - Dr. Hastreiter said
17 the only way it could have been contaminated would
18 have been if they had a cannula in the sinus,
19 Mr. Cimbura's finding from the point of view leaves
20 a scientist uneasy and I think as a result of all
21 of that discussion the vote the second time around
22 was changed.

23 Q. Is it fair to say then that
24 the reason your vote changed was primarily due to
25 the significance attached to that blood serum
reading?



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A. I think so. I think that I was always, when the toxicology was available and when the toxicologist said this is high or he is uneasy or he thinks this is high and there was a lot of that in the toxicology, that was a major factor in making my decisions and I think that that is the case here, I would say.

Q. Well then quite properly you were influenced by the opinion of an expert toxicologist?

A. Yes, yes I was.

Q. If indeed at some later time, on the basis of toxicological evidence or pharmacological evidence, doubt is cast as to the accuracy of that blood serum sample, I would then take it that you may well alter your opinion accordingly?

A. Yes, I would if that were the case because I am not a toxicologist or forensic toxicologist and I rely, as you do in your profession, I rely on expert opinions; some expert opinions I can judge very well indeed, other expert opinions such as toxicologists' opinions are really not within my general fund of knowledge.



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I have not made any special study of it and therefore I must be relying on it as I see, I must use it as it was given to me, and that is really the sum total of it.

Q. Dr. Fay, my reading of these Minutes is that Kristin Inwood was the only child upon whom, or for whom a second vote is recorded. Is that your recollection of what occurred at the meeting?

A. I can't remember those details, you know. I can't.

Q. In that case we will simply rely on what was put here in the report.

A. Yes.

Q. If I might direct your attention to page 22 of the report, or also page 240 at the top right-hand corner, and direct your attention to the case of Baby Gardner.

After a review of the relevant evidence, of the relevant findings in respect of this baby, a vote was taken and it appears that yourself and Dr. Hastreiter cast votes that this child should be placed in the category of "natural death". It appears that Dr. Bennet, Dr. Tepperman, Mr. Cimbura and Dr. Gilmore-Bryson cast a vote that



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she should be placed in the category of "low
suspicious".

A. Yes.

Q. So we can see from that
there was not unanimity amongst the medical experts
and toxicologists and Dr. Gilmour-Bryson as to
the categorization of this child; is that correct?

A. Yes.

Q. And then Sergeant Warr reported
the vote of the homicide team and in this case there
was a difference of opinion amongst the members of
that team inasmuch as two cast a vote for "probable
murder" and ten cast a vote for "suspicious death",
and that is what appears to be on the face of the
report, is it not, Dr. Fay?

A. Yes, yes.

Q. But the report does not
appear to disclose that a second vote was taken
in this case, does it?

A. No.

Q. So notwithstanding the
difference of opinion amongst the medical experts
and the difference of opinion between them and be-
tween the police, no request for a second vote was
made, was there?



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A. No.

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Q. And if I might turn your attention to page 242, or page 24 of the Minutes of this meeting, the case I believe, of Matthew Lutes.

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A. Yes.

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Q. Again reviewing the votes that were cast at that meeting, there did appear to be an agreement amongst the medical experts, Mr. Cimbura and Dr. Gilmour-Bryson that this child should be placed in the category of "natural death". That appears on the face of those Minutes, does it not, Dr. Fay?

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A. Yes.

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Q. That vote, however, seems to differ from the votes cast by the members of the Homicide team, does it not? They placed the child in the category of "suspicious death".

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A. Well, that is what Sergeant Warr is reported to have said. I can't remember what he said, but it is here in the Minutes.

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Q. I appreciate that. We are simply relying on the Minutes of the meeting.

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And again relying on the Minutes of the meeting, there does not appear to have been a second vote taken in this case, notwithstanding the difference of opinion between the medical people and



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the Homicide people.

A. No. That is true.

Q. And again if I might turn your attention to page 28, or page 246, of the Minutes of this meeting and, in particular, the top part of that page which records the votes cast in the case of Baby Volk.

Again it appears that the medical experts, the toxicologists and Dr. Gilmour-Bryson agreed on placing this child in the category of "natural death", did they not?

A. Yes.

Q. And that Sergeant Warr reported that the Homicide team had reached a different conclusion; that is, they placed it in the category of "suspicious death".

A. Yes.

Q. And again there does not appear on the face of the Minutes of that meeting to have been a second vote taken on that child, notwithstanding this difference of opinion?

A. No.

Q. So really at the end of the day we are left with four children in which there were disagreements initially between the medical



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experts, the toxicologists and Dr. Gilmour-Bryson
and the homicide team.

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A. Yes.

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Q. And yet in only one of those
cases was a second vote requested, and that is the
case of Baby Inwood, is that not correct?

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A. Yes.

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MR. BROWN: Thank you, doctor.
Those are all my questions.

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THE COMMISSIONER: Thank you.

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Mr. Strathy.

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You may have a much more resonant
voice than I have, but I got abused for speaking
away from the microphone and the same thing could
happen to you.

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MR. STRATHY: Well if people have
trouble with my voice, let me know. I just wanted
to be near my desk.

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THE COMMISSIONER: Won't that move
up?

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MR. STRATHY: No, it is taped to
the floor.

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THE COMMISSIONER: Oh, I beg your
pardon. Then you can't do anything else.



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2 CROSS-EXAMINATION BY MR. STRATHY:

3 Q. Doctor, just referring for
4 a moment to the Minutes of the meeting of September
5 13th, which are marked as Exhibit 261, let me say I
6 sympathize with your difficulty in having obtained
7 them recently - we only received them this Monday;
8 so bear with me in my review of them with you.

9 Let me ask you at the outset,
10 have you received Minutes of any other meetings that
11 you went to during the period of your assignemnt?

12 A. I received no Minutes of any
13 meetings until I met with Ms. Cronk last week.

14 Q. Quite so. But apart from
15 these did you receive any others?

16 A. Oh, yes. At that time I
17 got some Minutes of a couple of other meetings, yes.

18 MS. CRONK: As you might anticipate,
19 Mr. Strathy, I am on my feet.

20 THE COMMISSIONER: Yes.

21 MS. CRONK: Mr. Commissioner, there
22 is from Commission Counsel's point of view a diffi-
23 culty at this stage in Phase I in some of these
24 Minutes. The Minutes of the September 13th meeting
25 were, in our view, properly admissible and relevant
at this stage because clearly the contents of those



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2 Minutes went directly to cause of death. That is
3 not, in our judgment, the case with the other Minutes,
4 with the exception, I believe, of one set of Minutes
5 where it was intended to introduce them through Dr.
6 Hastreiter because, in some instances, at that meeting
7 he had made comments that go to cause of death. The
8 balance of the Minutes, in our view, are not
9 relevant to you at this stage of the Inquiry.

10 THE COMMISSIONER: Are they
11 relevant to the second stage?

12 MS. CRONK: In some instances they
13 may be, sir, and they have not been produced at
14 this stage for that reason.

15 THE WITNESS: I'm sorry, I think I
16 only received one other set of Minutes.

17 THE COMMISSIONER: One other set?

18 THE WITNESS: Yes, I'm sorry.

19 MS. CRONK: I may have been
20 brighter last Thursday than I realized. It may have
21 been in my mind even then.

22 THE COMMISSIONER: Yes. Do you
23 know which one you gave?

24 MS. CRONK: Can I just see this?

25 THE WITNESS: I think that was the
first.



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2 THE COMMISSIONER: There is a
3 problem about whether they are admissible or not.

4 MS. CRONK: The other copy of the
5 Minutes that were provided to Dr. Fay, in fact, a
6 compilation of the Minutes from several meetings,
7 they are stapled together so he thought he had one,
8 but he --

9 THE COMMISSIONER: Mr. Young, did
10 you want to say something?

11 MR. YOUNG: I am not one hundred
12 per cent sure just which Minutes of which meeting
13 we are talking about. I will tell you that I have
14 been through these Minutes, some Minutes of other
15 meetings, and as I pointed out yesterday, it is quite
16 clear that the dates of these meetings indicate they
17 were held during the second phase of the Police
18 Inquiry.

19 THE COMMISSIONER: Yes. But as you
20 know, they could be relevant to this issue.

21 MR. YOUNG: Absolutely, and that
22 is why we didn't object to the introduction of these
23 Minutes. Before any other Minutes go in I would
24 certainly appreciate the opportunity of reviewing
25 them.

THE COMMISSIONER: In any event you



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can look at them perhaps at the break and see -- or

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do you want to --

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MR. YOUNG: Is it being suggested
that these particular Minutes are relevant by anybody?

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THE COMMISSIONER: I don't know.
Mr. Strathy seems to want to have them.

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MR. STRATHY: I guess I too am
concerned. I haven't seen the Minutes and I would like
an opportunity to look at them before I make a
submission to you.

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THE COMMISSIONER: Yes.

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MR. STRATHY: The second concern
I have, as my friend concedes, we think Exhibit 261
is relevant since it goes to cause of death, and I
am concerned that we did not have it when Mr. Cimbura
was in the stand at the very least. I am less
concerned about Dr. Gilmour-Bryson. Certainly, I
would have thought that we might have had them when
Mr. Cimbura was in the stand so we could have
questioned some of the views he expressed at that
time. It may well be that we will want to make some
submissions to you about Mr. Cimbura's reattendance.

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In any event, maybe I can have a
chance to see the Minutes.

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THE COMMISSIONER: I don't know



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2 whether that is possible.

3 MR. LAMEK: I am not prepared to
4 do that, Mr. Commissioner. I can tell you that
5 until very recently, and indeed until Dr. Fay was
6 scheduled to come here, I had some doubts as to
7 whether these Minutes, indeed any of the Minutes
8 of meetings that were held, which frankly are
9 contained as part of the Police Report of which we
10 have heard a great deal, were admissible in this
or the second phase of the Inquiry or at all.

11 When it was clear that Dr. Fay
12 was coming and he attended this important meeting
13 of September 13th, when despite its express and
14 particular objective there was clearly material
15 discussed going to the question of cause of death
16 and it became clear that, with some small exceptions -
17 and those are matters that have been expurgated -
18 these Minutes were clearly relevant to this phase
of the Inquiry.

19 At that time, I reviewed all of
20 the Minutes of the meetings contained in the Police
21 Report and they are the ones of which copies have
22 been provided to Dr. Fay; and it was my judgment
23 that with the possible exception of some parts of
24 one other set of Minutes which might more properly
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2 be put to Dr. Hastreiter since they deal with remarks
3 attributable to him, the other Minutes were not
4 relevant to the cause of death as you are approaching
5 that, sir.

6 THE COMMISSIONER: I would just
7 like to say, though, that if you believe they are
8 relevant to the second phase, it might be wise to
9 distribute them now in any event, because there will
10 always be some question in the minds of other
11 counsel - not that you would do anything deliberately
12 unkind to them but that you might not appreciate
13 their case.

14 MR. LAMEK: I understand that, sir,
15 but at that point I run rather squarely into your
16 ruling the other day, that investigative matters
17 which do not go to matters falling within Phase I,
18 investigative matters occurring after the discharge
19 of Susan Nelles, are not within the scope of this
20 Commission.

21 THE COMMISSIONER: These are all
22 I take it after the discharge, are they?

23 MR. LAMEK: Unless they go to
24 matters involved in Phase I.

25 THE COMMISSIONER: Or Phase II.

MR. LAMEK: Or Phase II, Yes.



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2 MR. YOUNG: I don't mean to
3 interrupt Mr. Lamek, but it is the witness' evidence
4 that he didn't become involved until after the
5 preliminary hearing had ended.

6 THE COMMISSIONER: Yes. All right.
7 Wait now --

8 MR. LAMEK: I guess what I am
9 saying, Mr. Commissioner, is no matter what view I
10 may have entertained as to the admissibility of these
11 Minutes in Phase II prior to your ruling --

12 THE COMMISSIONER: Yes.

13 MR. LAMEK: -- that now has to
14 be reassessed.

15 THE COMMISSIONER: Yes. All right.
16 Yes, Mr. Knazan, you have a
17 problem?

18 MR. KNAZAN: I would like to put
19 my position on the record, and it is a bit stronger
20 than Mr. Strathy's perhaps.

21 I have never been comfortable with
22 the Phase I/II separation solely on the basis of
23 date or description. I want to make clear what I
24 am saying. That is, what transpired with respect
25 to investigation might affect the weight of some of
the evidence which you are hearing.



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2 Some of the other counsel -- the
3 problem, Mr. Commissioner, is a lot of times we have
4 to wait until April or May to make our argument,
5 and clearly some of our cases hopefully are
6 emerging the way we put our case in.

7 THE COMMISSIONER: Yes.

8 MR. KNAZAN: And some of the other
9 counsel share the snowball feeling in this case, a
10 couple of people get together and make a mistake about
11 the same nursing teams being on; then a nurse
12 advises a police officer that one nurse was on when she
13 wasn't; then, there is four that had the same nurse
14 on; all of a sudden, we have murder. When we have
15 murder, a lot of people died then, and the thing
16 snowballs. Then someone is charged and they are
17 discharged and then we have a Royal Commission. So,
18 if certain things had not transpired, we wouldn't
19 even be here for Phase I.

20 THE COMMISSIONER: Yes. All right.

21 MR. KNAZAN: There is some
22 clear example, for example, Dr. Gilmour-Bryson testi-
23 fied earlier in the Inquiry her participation in
24 these Minutes probably isn't relative to Phase II in
25 the strict sense - I am sorry, Phase I in the strict
sense of the term, but it may have been relevant for



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2 us to know her attitudes when she gave her testimony
3 about numbers of deaths.

4 That is my submission.

5 THE COMMISSIONER: Yes. All right.

6 MR. LAMEK: Mr. Commissioner, for the
7 moment, as counsel who called Dr. Gilmour-Bryson,
8 if there is any suggestion implicit in my friend's
9 remarks that her ability to count is in some way
10 coloured by her participation in these meetings, I
11 reject it.

12 THE COMMISSIONER: Yes. All right.

13 Yes, Mr. Brown.

14 MR. BROWN: If I might make a
15 brief submission, Mr. Commissioner.

16 The introduction of this particular
17 exhibit, the Minutes of the meeting of September 13th,
18 indicates that there was relevance to that information
19 in Phase I, that is, the cause of death. We have
20 reference in those Minutes to a meeting on Friday,
21 September 10th --

22 THE COMMISSIONER: Which may not have
23 discussed the cause of death.

24 MR. BROWN: Which may not have
25 discussed the cause of death but it does appear that
four categories were agreed upon. There may have



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2 been other discussions amongst the police themselves
3 as to how they were going to vote on the categories.

4 THE COMMISSIONER: Well, I --

5 MR. BROWN: The point I would like
6 to make, Mr. Commissioner, if I might --

7 THE COMMISSIONER: Yes.

8 MR. BROWN: -- is that although
9 there may be argument that ~~they~~ might not be grossly
10 relevant to Phase I, I think this must be taken in
11 context. This is a public inquiry. The Attorney
12 General has charged this Inquiry to make the fullest
13 investigation of the matters. It is gaining great
14 attention in the media, and indeed in the media
15 today these categories of eight probable murders
16 were splashed across the headlines. If the public
17 is going to understand what is transpiring at this
18 hearing, through the media, and the media reports
19 are in turn based on classifications set up by the
20 police or by the Crown Attorneys at which votes were
21 cast and categories set up, I submit they are relevant
22 to the cause of death and they should be brought
23 forth.

24 THE COMMISSIONER: I wish I could
25 get as worked up as you do about the state of the
media. I have enough trouble I feel, on my own and



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I will let them look after their problems.

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Mr. Olah.

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Obviously everybody wants to talk

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about their problems.

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MR. OLAH: We all have to put in our two cents worth.

THE COMMISSIONER: Yes, all right.

MR. OLAH: I am more concerned flowing as a result of your ruling that day about naming names, as a result of that, Mr. Commissioner, it is obvious in my respectful submission that involvement of particular parties becomes of concern to --

THE COMMISSIONER: Involvement of what?

MR. OLAH: Of particular parties, and any evidence that goes to that is of great concern, and for that reason and for the reasons that have been expressed already, in my respectful submission anything that touches on that area becomes highly relevant and important to my client and some of the other people involved and I would like to have the opportunity to see the material and --

THE COMMISSIONER: Yes, that is right. It occurs to me before I go any farther that the media or somebody - possibly the witness more than anyone else is going to have quite a tale to take home tonight about everybody arguing about the contents of a document that hardly any of them



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have seen. And this is what goes on all the time,
but I think before we get too worked up about it we
should pause for a moment and decide first of all
if Mr. Young is happy to have everybody see it and
if he is, that is the end of it.

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Secondly, perhaps I can take a look
at it and I can at least then know what we are talking
about.

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MR. OLAH: I certainly would be
delighted to have that.

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MR. YOUNG: I don't want to get
your hopes up.

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THE COMMISSIONER: You are not
going to.

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MR. YOUNG: I am not going to
agree with that, Mr. Commissioner.

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You made a ruling the other week
based on the Attorney General's - I'm sorry, the
Cabinet's Order-in-Council --

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THE COMMISSIONER: Yes.

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MR. YOUNG: And we are abiding
by it.

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THE COMMISSIONER: No, no, but if
the document appears to have some relevance to the
cause of death --

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MR. YOUNG: Our position is it does not, and I believe my friend Mr. Lamek said the same thing today.

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My friend Mr. Brown is anxious to have a very full finding and a full disclosure of these proceedings. Maybe we should start talking about murder when we mean murder and maybe we should start mentioning names when we are referring to them. That would be a way having a full --

THE COMMISSIONER: Well I think we have probably got a little out of hand now.

MR. OLAH: I certainly don't want to get caught in the crossfire between Mr. Brown and Mr. Young but I would be most delighted if you would take the opportunity and review it and I would appreciate that.

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THE COMMISSIONER: Well, at any rate I take it, Mr. Young, that your final position is that you are not going to agree to admission. I will either accept that as final but if I don't accept it as final we will have an argument on the question. Now what we do about looking at it or not I don't know. I may have to inform in substance what the documents say and have argument on that basis, but we can't have argument now on the basis of a



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document that we don't know --

MR. YOUNG: I quite agree and in fact the only people that have seen it are Mr. Lamek and myself and our position is quite clear. Oh, I'm sorry, Mr. Hunt has seen it as well.

THE COMMISSIONER: Is your position quite clear too?

MS. KITELY: Mr. Commissioner, at the risk of flogging a dead horse --

THE COMMISSIONER: It is not yet dead.

MS. KITELY: Could I just ask one thing I don't think anyone else has brought up and that is just this afternoon in response to a question put to Dr. Fay he was asked about the purpose of trying to reach a consensus and that was whether the parents were going to be contacted if their deaths were natural or otherwise.

THE COMMISSIONER: Yes.

MS. KITELY: And he said according to my note that he knows it was discussed; he doesn't know if it was on the 13th, but it was most certainly discussed.

To the extent that Dr. Fay has told us time and again in the last day and a half the very



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narrow purpose of his enquiry, to the extent that
it is in the one minutes that we have that was
supposed to be the narrow purpose of the enquiry in
my submission we have to have every single minute
and anything that relates to it.

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THE COMMISSIONER: Yes. Well, that
is certainly a nice broad position you take.

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MR. YOUNG: Let me just make one
other point: my recollection of these minutes is
that they do not contain anything relevant in view
of your recent decision.

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I will undertake to review them and
should my position change I will let you know, but
at this time that is all I can tell you.

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THE COMMISSIONER: Yes. All right.

Now, Mr. Strathy, all I can say is
that I am back to my original position in this Inquiry
of not making a ruling. But you go ahead with some
other matter and then I will have to deal with this --

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THE WITNESS: Excuse me,
Mr. Commissioner. I don't want to take undue time
but when I got involved with this I already knew,
of course, from what I read in the papers and heard
about the Inquiry with regard to Nurse Susan Nelles --

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THE COMMISSIONER: Well, now, wait,
please.



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THE WITNESS: Yes.

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THE COMMISSIONER: I don't want you

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to - be very careful because we haven't dealt with --

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THE WITNESS: But this has come up.

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THE COMMISSIONER: I know, but there

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are a lot of things that have come up that we have
controlled.

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THE WITNESS: I am not going to

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say anything that you will I think take --

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THE COMMISSIONER: I just wonder -

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I think we will take 15 minutes now and would someone

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please discuss this matter and we will take 15 minutes

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and then we will come back.

14

---Short recess.

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---Upon resuming.

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THE COMMISSIONER: Yes, Mr. Strathy?

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MS. KITELY: Before my friend actually

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commences I am obliged to leave before the day is

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over and I gather that my friend with his usual

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thorough approach won't finish today.

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THE COMMISSIONER: I don't know

whether he will find that as a compliment or otherwise.

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MS. KITELY: In the event that all

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of my firends are finished I do wish to cross-examine.

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THE COMMISSIONER: Well I think I

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can be reasonably optimistic for you, but I won't because we have to consider the witness as well. If by any chance we were through I am afraid I would turn on you.

MS. KITELY: Yes, I agree but I am reasonably confident --

THE COMMISSIONER: Yes, you have a right to be reasonably confident but if you and I are both wrong then --

MS. KITELY: Then I am out of luck.

THE COMMISSIONER: -- then Dr. Fay is on the next transportation to Kingston or wherever he wants to go.

MS. KITELY: Thank you.

THE COMMISSIONER: All right, yes, Mr. Strathy.

MR. STRATHY: May I know, Mr. Commissioner, where we stand on this issue?

THE COMMISSIONER: No ruling, no ruling yet.

MR. STRATHY: But it is being reviewed, is it?

THE COMMISSIONER: At the moment I am waiting first of all to hear from Mr. Young as to what his position is because he hasn't taken an



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absolute stand.

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When he does, if he says it can go,
it can be released, that is the end of it. If he
says it can't I will then take a look at it and then
decide what to do.

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MR. STRATHY: The only thing I
can say, and I won't prolong it, obviously the only
thing I want to do is look into the material that
the witness had before him when he gave his opinion.
I want to be able to question --

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THE COMMISSIONER: He has already
told you he didn't have any minutes at all until he
got them --

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MR. STRATHY: I know that, but I
am entitled to go into the background behind his
opinion.

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THE COMMISSIONER: But the minutes
would not be a background to his opinion because he
didn't have them.

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MR. STRATHY: The information
referred to in the minutes obviously was --

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THE COMMISSIONER: Oh, that might
assist you in your cross-examination but that isn't
something that he had that you have to have for that
purpose. The only purpose that it could be of



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2 assistance to you might be for cross-examination of
3 this witness or perhaps with some other witness.

4 MR. STRATHY: That is right.

5 THE COMMISSIONER: And if I think
6 it would be then I will call on the police for agru-
7 ment on the question and set aside some time for that
8 purpose.

9 MR. STRATHY: Thank you.

10 THE COMMISSIONER: Unfortunately
11 I don't know how to handle it if I think it wouldn't.
12 I know I am not the one that should be judging your
13 case for you. I don't see how I can do it otherwise.
14 I will just simply have to do what I can.

15 All right, now, let's get on with it.

16 MR. STRATHY: Q. Doctor, you told
17 us that initially you were contacted by Coroner
18 Bennett and invited to participate in this exercise.

19 Did you have an understanding or
20 do you have an understanding as to the party by whom
21 you were retained? May I be specific: were you
22 retained by the police, the Attorney General, the
23 Coroner?

24 A. I find it difficult. The
25 word "retain" is a little foreign to me, and I would
say that in the first instance I thought I was



1
2 retained by the Chief Coroner, and certainly at the
3 first meeting met Mr. Jerome Wiley and I think
4 Mr. Robert McGee, and it was unclear to me just
5 exactly what my relationship was with the Crown
6 Attorney's Office but I sent the final reports in
7 through the Crown Attorney, Mr. Jerome Wiley, so I
8 suppose it would be correct to say that I thought
9 I was retained in the first instance by the Chief
10 Coroner and to some extent by the Crown Attorney's
11 Office I suppose.

12 Q. Ultimately your report which
13 we have before us was sent to the Crown Attorney,
14 though.

15 A. Yes, it was.

16 Q. Maybe one way of ascertaining
17 who retained you is to determine who paid your
18 fee.

19 A. The Crown Attorney's Office
20 paid my expenses and fee.

21 MR. STRATHY: That is a good
22 indication --

23 MR. ROLAND: It sounds like
24 Mr. Gordon Sinclair.

25 MR. STRATHY: Q. Now, Doctor, you
have told Miss Cronk a little bit about your practice



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and I understand you practice in Kingston.

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Could you describe the nature of
your practice? What is your practice outside the
hospital?

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A. Outside of the hospital?

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Q. Yes.

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A. I don't practise outside of
the hospital.

9

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Q. I beg your pardon?

11

A. I don't practise outside of
the hospital.

12

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Q. Then your practice is entirely
within the hospital?

14

A. Absolutely, yes. Yes, it is.

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Q. Can you describe the nature
of it? If you are telling me the sort of work you
do, what would you tell me? How would you describe
yourself?

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A. I am a cardiologist on staff
of the Kingston General Hospital engaged in the
practice of adult and pediatric cardiology, and I
am a member of both the Department of Medicine and
the Department of Pediatrics.

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Q. In terms of your daily work,
Doctor, how does it break down as between adult and



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pediatric?

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A. Oh, certainly a preponderance
of adult cases.

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Q. And has that been so over the
last 10 or 15 years?

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A. It has been so for the last
23 years.

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Q. Are you able to give us
percentages?

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A. Oh, I could give you accurate
percentages if I went back and toted up cases, but
I would say something like 15 to 20 to 80, 85.
Something like that children to adults.

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Q. 20 per cent children?

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A. Yes, that would be - yes,
15, 20, something of that sort; a definite preponderance
of adult cardiology.

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Q. And we have heard evidence
to the effect that there is a significant difference
between adult and pediatric cardiology in the sense
that in pediatrics you are generally dealing with
deformed or defective hearts from the beginning
whereas with adults you are dealing with hearts that
have become diseased over the years?

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A. Oh, well, of course there is



1
2 congenital heart disease in adults, but not - a
3 preponderence of heart disease in adults is coronary
4 heart disease. Hypertensive heart disease.

5 Q. By and large you would agree
6 there is a significant difference?

7 A. Oh, very different, yes.

8 Q. You mentioned that you did
9 your fellowship at the Sick Children's Hospital in
10 pediatric cardiology?

11 A. With Dr. Rowe, Dr. Keith --

12 Q. Dr. Rowe and Dr. Keith?

13 A. Dr. Keith, yes.

14 Q. Was Dr. Bain there at the time?

15 A. Yes, he was a senior staff
16 man at that time. Is that Dr. Harry Bain, is it?

17 Q. Yes.

18 A. Yes.

19 Q. As you have made it clear in
20 your evidence set out in the statement that you have
21 a great deal of respect for the doctors in pediatric
22 cardiology at Sick Children's Hospital.

23 A. I have the greatest respect.
24 In fact I refer patients to them and I refer newborn
25 infants to them and I have a close liaison with them
because I require their expertise to help us with



1
2 the problems especially the problems of the neonates
3 who are often airlifted here from Kingston. Or sent
4 by ambulance.

5 Q. Would that be a - would you
6 normally do that? Would you normally do that?
7 Would you normally, with a child with congenital
8 heart disease at your hospital born with congenital
9 heart disease, would you normally send that child
10 to Sick Children's?

11 A. I have an understanding - we
12 have an understanding between ourselves and my
13 colleagues in pediatrics at Kingston and Dr. Rowe
14 and his colleagues at the Hospital for Sick Children
in the Division of Pediatric Cardiology.

15 We do not do invasive studies, that
16 is cardiac catheterization, angiography, in newborns,
17 in neonatal children who have problems with congenital
cardiac defects.

18 If they need to be investigated that
19 way, if they are in trouble because of cyanosis or
20 severe cyanotic heart disease or heart failure, we
21 make arrangements that we have an excellent working
22 arrangement to send them to the Hospital for Sick
23 Children under Dr. Rowe and his colleagues.

24 We do not consider it correct in this
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2 day and age to be invasively investigating such babies,
3 and I am talking about the neonates now because we
4 do not do heart surgery on neonates and therefore
5 our liaison and association with the Hospital for
6 Sick Children is most valuable to us and very, very
7 helpful.

8 Q. So do I understand then that
9 the cardiac catheterizations with respect to your
10 patients, Kingston patients, would be done at Sick
11 Children and heart surgery with respect to congenital
heart disease would be done at Sick Children?

12 A. Always on the young infants
13 and neonates, yes.

14 Q. Neonates?

15 A. In the first few weeks of
16 life.

17 We are in a better position nowadays,
18 of course, in sorting this out because sometimes it
19 is difficult to know whether this baby really does
20 have a cardiac condition because we have excellent
21 up to date echocardiographic diagnosis available
to us.

22 So we know what sort of problems we
23 are asking our colleagues to take over, but we have
24 a very close liaison. We know who is on duty. We
25



1
2 know who the staff cardiologist is.

3 Q. I take it it wouldn't be
4 stretching things to suggest that in the course of
5 a year Dr. Rowe would see a great many more pediatric
6 cardiology patients than you would?

7 A. No question at all.

8 Q. And for the reasons you have
9 given you would have great respect for the views of
10 Dr. Rowe and his colleagues at Sick Children's?

11 A. Always have had.

12 Q. And you quite properly
13 indicated you have not discussed your views with
14 Dr. Rowe and I take it Dr. Rowe has not made his
15 views known to you? In specific cases.

16 A. Not at all. Not at all. I
17 would have considered it and obviously Dr. Rowe felt
18 the same way I did. We haven't discussed these
19 children.

20 Q. Am I also correct you have
21 not read Dr. Rowe's transcript of his evidence,
22 Dr. Bain's evidence, Dr. Fowler's evidence, Dr. Rose's
23 Any of the other cardiologists' evidence?

24 MR. ROLAND: My friend doesn't
25 know this but I asked Dr. Fay for my purposes to
assist me in shortening my examination to read some



1
2 of Dr. Rowe's evidence last night and I think he did.
3 I gave it to him to read.

4 THE WITNESS: And I read it.

5 MR. STRATHY: Quite proper.

6 THE COMMISSIONER: Some of it has
7 been read to him in this room.

8 MR. STRATHY: Q. All right. Apart
9 from that, may I suggest, Doctor, that had you been -
10 or if you did in fact have an opportunity to hear
11 the views of Dr. Rowe and his colleagues your opinions
12 might well have been influenced by their views?

13 A. Well, I gave two examples
14 this morning of my opinion being influenced in this
15 very situation by the views of Dr. Izukawa in an
16 opposite way if you like, and Dr. Bob Freedom, so I
17 have given you two examples of that.

18 Q. And I am sure you concede
19 that there may well be other examples if you were
20 pointed to specific things?

21 A. Yes, because these were the
22 cardiologists, very experienced cardiologists,
23 knowledgeable cardiologists, who looked after these
24 children during the time that they were sick and in
25 Hospital.

Q. I assume from that that you



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would agree that any doctor who actually observed
the patients in the Hospital setting, clinical, would
have a distinct advantage over you looking at it
from a secondhand point of view from the chart?



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A. From what point of view?

Q. In terms of determining the reasons for the child's death.

THE COMMISSIONER: Surely not any doctor.

MR. STRATHY: Well, let me be more specific then. The doctors at the Sick Children's Hospital in the Pediatric/Cardiology Service who actually treated the children, saw them in the Hospital, observed their progress, would be in a better position to comment on the reasons for the child's death than you would reviewing it only a second time from the chart?

A. Yes, they would, they would, I agree, of course. I tried to make this point and I clearly am labouring it and I don't think I am doing it very well but I will do it again. I am looking now in a very narrow way at a specific - I am being asked a specific question about this child, about these charts. I am not being asked about the accuracy of the diagnosis or the management of the child or anything of that sort.

Q. I am not suggesting that.

MR. LAMEK: Let him finish his answer.

MR. STRATHY: Q. All right.



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A. Or anything of that sort, I am being asked in this setting, could this child have died of an overdose of digitalis. That is the only question I was asked.

Q. Well, let me be clearer. Suppose that question is put to you and suppose that question is also put to one of the doctors or the doctors responsible for the particular patient?

A. Yes.

Q. I suggest to you that the doctor responsible for the particular patient, having seen the patient's clinical course, having seen the various tests done on a patient, would be in a better position than you to answer that question?

A. Oh, yes, I am just looking at a chart, that is perfectly correct, I agree with you, but there was toxicology supplied to me.

Q. I understand, I am just comparing the two, Doctor, and I think you fairly state that the doctor in the hospital treating the child would be in a better position to come to that conclusion?

A. He has a better opportunity



1
2 and is in a better position to observe the child's
3 clinical course. There is no question about that.
4 I don't have a chance to do that at all, I am
5 just looking at a written record after the child's
6 death.

7 Q. Are you called into consult
8 from time to time by other doctors?

9 A. I only do a consulting practice.

10 Q. I see. Well then, you are
11 called in from time to time?

12 A. Frequently.

13 Q. And presumably one of the first
14 things you want to do is take a look at the patient.

15 A. You can't consult in medicine
16 without seeing the patient.

17 Q. Thank you. Now, I just want
18 to be clear about the procedure that was followed
19 with respect to your assignment, Doctor, because
20 I wasn't I'm afraid entirely clear. You told us
21 you were called in by the Chief Coroner. Can you
22 tell us when you first physically became involved
23 in the case, when did you first begin to immerse
24 yourself in it?

25 A. The first meeting I attended,
which I have stated previously, was at the Police



1
2 Headquarters, it was June 30th. I couldn't remember
3 the date but it must have been June 30th, at which
4 time I first met Mr. Wiley and Mr. Robert McGee,
5 I believe the Chief Forensic Pathologist, Dr.
6 Hillsdon-Smith was there, Mr. Cimbura was there,
7 Dr. Hâstreiter, there were a lot of police officers
there. I can't remember really.

8 Q. And that was in the Toronto
9 Police Headquarters?

10 A. Sixth floor.

11 Q. And were you provided with any
12 information with respect to any of these children
at that time?

13 A. Well, I heard some children
14 discussed. I didn't make any notes and I told
15 you I didn't have any minutes and I never received
16 any minutes and then I was told that the charts
17 that I was to look at were at the Hospital for
18 Sick Children. I don't know when I first went to
19 the Hospital for Sick Children, it probably was
20 shortly after that meeting. I think the meeting
21 was in the morning and then in the afternoon I
22 think I went to the Hospital for Sick Children
23 where there was a room which had been assigned
for this purpose, reviewing the charts. There were
24
25



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2 police officers there also. Dr. Hastreiter wasn't
3 there while I was there and Mr. Wiley would come
4 and go. I began work on the charts, picking them
5 up and making a note. I was told that these are
6 the charts here that have to be reviewed and I
7 went at it and I came back several days to complete
8 this task.

8 Q. So, did you stay in Toronto
9 for a period of time until this task was completed?

10 A. No, I didn't. It was done
11 over a period of a couple of - well, several weeks
12 I suppose. I stayed a couple of days at a time.
13 I reviewed, I am told it is 49 charts. I know I
14 reviewed a great many charts, more than are here
15 in this volume, this binder.

15 Q. And during the course of that
16 review, you prepared the handwritten notes that
17 we see in Exhibit 259?

18 A. Yes, I jotted down the notes
19 as I looked at the charts.

20 Q. Now, were all the handwritten
21 notes that we see in Exhibit 259 made by you while
22 you were reviewing the charts or were they made
23 at other times?

23 A. No. Well, you know, I am not
24
25



1
2 sure that I didn't put in some of the toxicology
3 afterwards, I don't know, I am not sure. I think
4 I probably did. Other than that, my notes were
5 made at the time I was reviewing the chart, yes.

6 Q. So, the notes concerning the
7 clinical condition, diagnosis and so on were made
8 while you were reviewing the chart?

9 A. Yes.

10 Q. And your best recollection
11 today is the notes of the toxicology may have been
12 made at some other time?

13 A. Some of the toxicology infor-
14 mation may have been made at another time, I really
15 can't say. Not much was made at any other time.
16 I think there is no question the majority of the
17 notes were made as I reviewed the chart.

18 Q. And do you know when it was
19 that the additional toxicology information was
20 added?

21 A. There were some other meetings
22 at the Police Headquarters. There was one short
23 meeting at the Hospital for Sick Children in addition
24 to the 13th of September meeting, and I can't
25 remember when that was. Again, no minutes. I think
at all these meetings toxicology was brought up at some



1
2 time. I don't know what notes I made at that time
3 but toxicology was brought up from time to time
4 in these general discussions.

5 Q. The ones you are mentioning
6 at the Police Headquarters and the additional
7 meetings at the Sick Children's Hospital?

8 A. Yes, yes, yes.

9 Q. And is it possible you added
10 this toxicology information to your notes as it
11 came in to you in dribs and drabs?

12 A. I don't think I added much at
13 those meetings. I never got it, as I have said
14 previously, in a report form in my hands that I had
15 it all listed and categorized and so forth. There
16 was an on-going investigation by the toxicologist,
17 by Mr. Cimbura's laboratory, because they were going
18 back to tissues, they were going back to the Hospital
19 for tissues which had been retained in the Department
20 of Pathology, there were exhumations being arranged.

21 Q. Doctor, I don't mean to cut
22 you short but all I am really trying to find out
23 is when it was that you added this information to
24 your notes?

25 A. I think that the majority of
that information came on two occasions; one, if I



1
2 looked at the police record after I had reviewed
3 the charts, the one I have referred to before
4 in the brown envelope, which would have some
5 toxicology on it, and I think that I certainly got
6 some information for the first time I suspect,
7 to record on the 13th of September, I think that's
8 correct.
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Q. So then at this meeting on the 13th of September at the Sick Children's, do I understand you were adding to your notes at that point as well?

A. I may have.

Q. All right. And if you didn't add the toxicology in then, you added it from the police file while you were reviewing the charts themselves?

A. Yes. I didn't touch my notes after the 13th of September.

Q. So, just to be clear, Doctor, there were two times then, when you were reviewing the police file at the time you made your chart review?

A. Yes.

Q. And the meeting of September 13th?

A. Yes. Yes, I think that must be the best that I could recollect.

Q. Thank you. And do I understand also that in addition to the meetings which you had at the police headquarters you had separate meetings with Mr. Cimbura?

A. No, I had no separate meetings



1
2 with Mr. Cimbura.

3 Q. I'm sorry. Then you did not
4 attend at the Centre of Forensic Sciences?

5 A. Never went there.

6 Q. I see. But Mr. Cimbura was
7 present at some of these meetings at police head-
8 quarters?

9 A. Oh, yes, yes, he was. I
10 think he was there all - well, I think he was there
11 on three out of four occasions, whenever it was I
12 went there.

13 Q. And after September 13th, '82,
14 did you have any further involvement in the matter
15 until January of 1983 when you submitted your report
16 to Mr. Wiley?

17 A. There was one other meeting
18 after the 13th of September at, again, at police
19 headquarters and it broke up at lunch time and that
20 was the last meeting I attended and then my last
21 involvement was to send my dictated tapes to
22 Mr. Wiley's office and then to go to the police
23 office, homicide office. I can't tell you where that
24 is now, and correct the drafts for the final report.
25 That was it.

THE COMMISSIONER: I'm sorry, you



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sent the tapes themselves?

THE WITNESS: Yes, I did.

THE COMMISSIONER: You dictated the tape. You sent the tapes, you didn't have them typed in Kingston?

THE WITNESS: No, I didn't have them typed in Kingston, no.

MR. STRATHY: Q. Just out of interest, Doctor, why was that?

A. Well, I thought there was a certain amount of confidentiality about it. I thought it was best. That's why I left these notes that had been all copied, I didn't take them around with me.

Q. That's fine, thank you.

The meeting after September 13th, '82 that you mentioned, what was the purpose of that meeting?

A. That's a good question. I'm not sure what the purpose of that meeting was. I know it was the end, it was sort of the winding up meeting I suppose it was, that was as far as I was concerned it was.

Q. Was a further review done of the deaths?



2EE4

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3 A. Well, obviously that was the
4 whole purpose of my attending the meetings was to
5 talk about the children who had died, so, there
6 must have been some comments. Without my reading
7 the minutes of the meeting which occurred 14 months
8 ago I can't tell you what was discussed.

9 Q. Well, was it at that meeting
10 that the two lists that we have heard about was
11 prepared, the list of natural and non-natural, do
12 you recall that being done?

13 A. The two categories?

14 Q. Yes.

15 A. I don't remember the two
16 categories being brought up at that time, not to
17 my knowledge.

18 Q. Well, do you remember anything
19 in general that was done at that meeting after
20 September 13th?

21 A. Nothing of importance as far
22 as my work was concerned.

23 Q. Do you recall specific deaths
24 being discussed?

25 A. No.

Q. What do you recall being
discussed?



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A. Nothing very much.

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Q. Well, for the purposes of

4

refreshing the witness' memory perhaps and assisting

5

me in cross-examination, I would like to have my

6

friend Mr. Young add those minutes of the subsequent

7

meeting to my request, it would give me an opportunity

8

to review them

9

THE COMMISSIONER: I take it they

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were always part of it, were they not? Were they

11

not always part of it? Are these the minutes that

12

we are talking about?

MS. CRONK: Yes.

13

MR. STRATHY: Excuse me, all right.

14

THE WITNESS: I would like to be

15

able to assist you but I really can't remember.

16

MR. STRATHY: Q. Well, Doctor,

17

maybe we will be able to assist you if Mr. Young and

18

his clients make the information available.

19

Just looking for a brief moment at

20

the minutes of September 13th meeting, Doctor, it

21

does appear as you have said already that you and

22

Dr. Hastreiter and Mr. Cimbura were the, if not the

23

key participants, at least the key actors or talkers

24

of the meeting. Does that accord with your

25

recollection?



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A. I think you could say that,
yes.

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Q. And just out of interest, do
you know whether Dr. Bennett or Dr. Tepperman have
any qualifications as cardiologists or pediatricians?

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8

A. As cardiologists or pediatricians.
They are not specialized in cardiology as far as I
know.

9

10

Q. Nor in pediatrics?

11

A. I don't know about Dr. Tepperman;
I don't think Dr. Ross Bennett is.

12

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Q. All right. And do you recall,
Dr. Gilmour-Bryson was there and we know that she is
a PhD doctor, but do you know whether she expressed
any opinion on the medical conditions of any of the
children?

16

17

18

A. No, I don't think she was
expressing a medical opinion. She had been looking
at other aspects.

19

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21

Q. All right, Doctor, I just
wanted to know whether she expressed a medical
opinion or not.

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A. No.

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Q. Mr. Cimbura I gather was the
source of your toxicology information at this meeting?



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A. Yes, he was the only toxicologist as far as I was aware that was giving us information.

Q. And it is clear from your evidence, Doctor, that you in coming to your opinions on specific children placed a good deal of weight on the toxicological evidence?

A. Yes.

Q. It is of considerable import to you where there is toxicological evidence?

A. Yes.

Q. Would it be fair to say that in some cases at least Mr. Cimbura himself expressed reservations about the interpretation of that toxicological evidence?

A. Yes, he did.

Q. He perhaps was at a loss in some instances to explain it?

A. Yes.

Q. Or to indicate what it meant in terms of causation?

A. Yes, especially in some of the tissue that was very, very old.

Q. Well, that would be some of the exhumed tissue?



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A. Yes.

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Q. I'm sorry, is that a yes.

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A. Yes, that's what I understood.

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Q. Doctor, in terms of the toxicology and the significance of the digoxin measurements, I would like to read you a statement and ask you if you are able to agree with it in terms of the establishment of digoxin toxicity, because that after all is what you are asked to look at in this exercise?

A. Yes.

Q. And the statement is this.

THE COMMISSIONER: I'm sorry, don't we have to have the source?

MR. STRATHY: Yes, I will give you that Mr. Commissioner. It is in Dr. Hastreiter's report on page 27, this is as yet I think unfiled, an unfiled report, and I really don't see any reason, I believe I asked some time ago that it be filed as an exhibit.

THE COMMISSIONER: It may have been, I don't know, I remember it was discussed.

MR. LAMEK: No it has been distributed.

MR. STRATHY: The Commissioner does not have it.

MR. LAMEK: Yes he does, he does now, he was put on the mailing list at his own request.

THE COMMISSIONER: I don't have it here,



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can I say that?

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MR. LAMEK: That I am not responsible
for.

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THE COMMISSIONER: Are you sure it
was not made an exhibit?

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MR. LAMEK: No.

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THE COMMISSIONER: That is the easiest
way to have it here is simply make it an exhibit.

9

10

MR. STRATHY: Perhaps to have it made
an exhibit nun pro tunc from the time the
Commissioner received it.

11

12

THE COMMISSIONER: Yes.

13

MR. STRATHY: May I ask that it be made
the next exhibit then.

14

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THE COMMISSIONER: I don't see why it
should not be made an exhibit. Have you any reason
why you want to hold back on that?

16

17

MR. LAMEK: No.

18

THE COMMISSIONER: Have we got a copy
of it that you can give to the Registrar?

19

20

MR. LAMEK: No, not now, we will make
it an exhibit in the morning.

21

22

MR. OLAH: We have an extra copy here
Mr. Commissioner.

23

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THE COMMISSIONER: All right, have you



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marked it up?

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MR. OLAH: Well, it is highlighted.

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THE COMMISSIONER: No, I think we will wait until tomorrow morning and we will make it an exhibit then.

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MR. STRATHY: Q. Doctor before we begin, you have already indicated to us that you have a good deal of respect for Dr. Hastreiter's opinion as a pediatric cardiologist and a man knowledgeable in digoxin?

11

A. Yes.

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Q. In the statement he makes, at page 27, which is as follows:

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"In my opinion the only true proof of digoxin toxicity is the demonstration of high concentration of the drug in blood or tissue. Digoxin intoxication can mimic many other conditions and particularly in infants who are seriously and acutely ill from other causes the differential diagnosis can be extremely difficult."

22

Is that a statement Doctor with which you are prepared to agree?

23

24

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A. No disagreement whatsoever.



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Q. And may I take it that that is the reason why you consider this toxicological evidence so important, is for the very reasons that Dr. Hastreiter states?

6

A. Yes.

7

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Q. And obviously as I think you have said from your evidence, the interpretation of that toxicological data is really an area where you are not qualified to give an opinion?

10

A. No, I am not a toxicologist.

11

Q. Nor are you a pharmacologist?

12

A. No.

13

14

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Q. And what that data means in terms of when a dose was administered; how it was administered; by what means it was administered; is really something that is beyond your expertise?

16

A. That is correct.

17

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Q. Thank you. Now if I can take you Doctor to a specific case. First of all, it is the case of Baby Hines, and if you look at page 21 of Exhibit 261.

21

A. Page?

22

23

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Q. I am sorry, it is of the minutes, Doctor, page 221, page 3 in effect of this smaller document?



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A. Yes.

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Q. At the bottom of the page,
near the middle of the last paragraph there is a
reference to Dr. Hastreiter. Dr. Hastreiter says:

5

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"Playing the role of Devil's advocate,
he stated the argument for SIDS is
very good."

7

8

Do you see that?

9

A. Yes.

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Q. "The baby may have missed SIDS
earlier with spells where he stopped
breathing. He said the great difficulty
would be to explain the digoxin levels."

13

14

Do you remember Dr. Hastreiter suggesting at that
meeting that there was a good argument for SIDS?

15

A. Yes, I do remember that point.

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Q. And if I indicate to you that
Dr. Bain, in his evidence before the Commission, as
indicated, testified that SIDS is a probable
explanation for the death of this child, and that
Dr. Becker, a pathologist of considerable repute
in the field has suggested that SIDS is an explanation
for the death of that child; would you be prepared
to say in light of Dr. Hastreiter's opinion that
SIDS offers an entirely plausible and acceptable



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reason for the death of this child?

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A. Yes, I think that is true.

4

There was, and I remember discussion, I think perhaps considerable discussion about SIDS at that meeting, considering we were looking at so many charts in such a relatively short time, considerable.

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Q. Well all I want to do Doctor, is ask you perhaps - and let me put it this way, absent the digoxin information?

19

A. Yes.

20

21

Q. And knowing what I have told you about Dr. Becker's and Dr. Bain's evidence?

22

A. Yes.

23

24

25

Q. Concerning this child, would you be prepared, are you prepared to accept SIDS as an explanation and a reasonable explanation for



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this child's death?

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A. Yes, certainly, especially

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with the pathologist's findings, yes.

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Q. If I can take you to your

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own report at page 83?

7

A. Yes.

8

Q. At the very top of the page,

2

page 83, on the right-hand side you have a notation

9

"possible", do you see that?

10

A. Yes.

11

Q. And my question is whether you

12

recall when you put that notation on the piece of
paper?

13

A. Well, as far as I can remember

14

the notations that I put there were made at the

15

same time that I was reviewing the chart.

16

Q. And are you talking about all

17

the notations on that page?

18

A. No, because the other one

19

comes later, I would have got that from the

20

envelope in the large container for the chart,

21

so it would not have been exactly the same time.

22

Q. But it was the same, you

23

reviewed the chart and the envelope at the same time?

24

A. The same session, yes.

25



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Q. So within the same day, within

3

the same hour?

4

A. Within the same general time

5

period, yes.

6

Q. So may I take it that when you

7

put that "possible" on that page you were aware of

8

two things: (a) that there was no digoxin ordered

9

for the child as you have noted just underneath

10

"possible"; and (b) you were also aware that

11

"dixogin" had been found in that child's - or some-

12

thing, and I put digoxin in quotation marks.

13

A. That is absolutely so, quite

correct as far as I recall.

14

Q. Quite correct that ~~it~~ should be

in quotation marks or quite correct --

15

A. What you say is correct.

16

Q. What is it that I say that

17

you agree with.

18

A. Where you said that I was

19

aware also that no digoxin had been ordered.

20

Q. Thank you. And that something

had been found in the child's tissue?

21

A. Yes I think that is true,

22

yes.

23

Q. And it was knowing that that you

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put "possible" on that page, is that so?

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A. That is right.

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Q. And then Doctor, if I can ask you to look at your cards that you prepared, your summary?

6

A. On this same case?

7

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Q. Yes, at page 29 and this is Exhibit 262; I'm sorry, Exhibit 262, page 29, do you have that?

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A. I have got them with the report.

12

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Q. All right, as long as you have what was once a yellow card.

14

A. Yes, that's right, once a yellow card, I have got it.

15

16

17

Q. You have on that card, it appears to me at least that it was originally a quote "B" and the "B" is scratched out and you have an "A", do you see that?

18

19

A. Yes, I do.

20

21

Q. Am I right that your initial view was that the child was in the "B" category and you subsequently changed it to "A"?

22

23

A. Yes I think that is right. Except if you go back, I don't know what A and B

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weighing is, you know, because if you look at the start of those minutes we are talking about A and B talking about being the same as a good possibility, so I don't know how much change that represents, but I would say an upgrading from a possible to a probable, yes.

Q. Well my question is the

"B"?

A. Yes.

Q. That was initially on the

card?

A. Yes.

Q. When did that "B" go on the card?

A. At the same session the "A"

went on the card.

Q. Then when you went to this

meeting on the 13th?

A. Yes.

Q. Had you put anything at all

on the cards?

A. No, my categorization I think

my -

Q. Let me just explain Doctor,

it is of some significance to us.

A. Yes.



1
2 Q. To know the state of mind that
3 you were in in the case of a particular child, what
4 opinion you had formed in the case of a particular
5 child when you went into that meeting. What I am
6 interested to know is whether that "B" we see
7 in Hines was a "B" before you went into the meeting
8 or "B" that was placed on the card at the beginning
9 of the meeting and subsequently upgraded to an
"A"?

10 A. I think the categorization I
11 had was on my written notes and I think that was
12 written at the meeting, I think it was written
13 at the meeting.

14 Q. Would it help you at all if
15 you had the original card to look at?

16 A. It might, it might help me
17 if I could read the card.

18 Q. Do you know where the original
19 document is. Perhaps Miss Cronk, or Mr. Lamek,
or perhaps the Police can --

20 A. It was left with the police,
21 I left it at the police office.

22 MR. YOUNG: I will add that to my list
23 and look into it Mr. Commissioner.

24 Q. I would be interested in seeing
25



1
2 not only the original cards but also the original
3 notes of the witness as well because that might help
4 us as to where different things were put on.

5 MR. YOUNG: I will get as much paper
6 as I can Mr. Strathy.

7 MR. STRATHY: I am not interested
8 in volume just the quality.

9 THE WITNESS: It is good quality.

10 MR. YOUNG: I have no doubt.

11 Q. In any event, Doctor, is it
12 fair to say that your best recollection today is
13 that going into that meeting on the 13th of
14 September, your view of the case was expressed in
15 your notes of the particular child and not on the
16 card?

17 A. I am fairly certain that is
18 the case, yes, I am fairly certain. I think all
19 I had - the purpose of the card was to have the
20 child's name and put it into alphabetical order
21 so I could file through quickly and pull the
22 thing for discussion. The purpose of the card
23 wasn't originally, as I remember, putting it
24 there for a categorization purpose, it was simply
25 an alphabetic listing and I used it to put a
category, I can't remember quite frankly.



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Q. I think it is far better to say, because I think we can all sympathize with you, Doctor, because some of us have trouble remembering what we had for breakfast two days ago. We can sympathize with your situation and if you don't remember, Doctor, I think it is far better that you say you don't remember in a particular case. Is that fair, you don't remember when you put that "B" on the card?

A. Well I just said I don't remember. I am trying to search my mind, because you keep questioning me, and when I search my mind then you tell me to say I don't remember, well I don't remember.

Q. I am only trying to be fair to you, Doctor.

A. You are being very fair.

Q. I beg your pardon?

A. You are being very fair.

Q. Now, if you look at the bottom of page 20 of the minutes of the September 13th meeting?

A. Yes.

Q. Page 220 underneath the child John Hines?



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A. Yes.

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Q. Do you see that?

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A. Yes.

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Q. About three lines up from the

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bottom of the page it says:

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"Dr. Hastreiter stated that on the

8

basis of a normal heart and doing

9

relatively well - not very sick -

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he would classify this as a good

11

prospect of massive overdose."

12

I take it you would agree with me that is some

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distance from your note on page 83 of your case

review of "possible", would you agree with that?

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A. Oh, yes.

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Q. Yes. Dr. Hastreiter is saying massive overdose, you are saying possible. But if you look over the page, page 221 of the exhibit --

A. Yes.

Q. -- it says:

"In introduction, Dr. Fay explained he had used categories A, B and C which would correspond with Dr. Hastreiter's categories of Good (A), Fair (B) and Small (C)."

Now, it doesn't seem to me from what we have seen that that is correct. It doesn't appear that you used A, B and C, or does that refresh your memory that you did in fact use those categories before the meeting? Does that help you?

A. If that is correct, it suggests that I had put a notation on the card and perhaps if we could look at the card it will become obvious but I can't remember.

Q. Perhaps if we could see the card tomorrow morning that will help us.

A. Sure.

THE COMMISSIONER: We might be able to. Are there any Ds in your card?

THE WITNESS: Any Ds?



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THE WITNESS: Any Ds?

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THE COMMISSIONER: Ds. All we have to do is look at a natural death and see if one of the ones you had in natural death has a D on the card.

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MR. STRATHY: Well, except on the witness', I think we have got Cs.

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THE COMMISSIONER: No, I know. You see, the categories that were set forth by the police were A to D.

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MS. CRONK: You will see, sir, in respect to those children where Dr. Fay ultimately categorized them as natural, the word "natural" appears on the card and in some cases the letter C with "natural" beside it.

15

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THE COMMISSIONER: Yes, but there are no Ds.

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My suspicion, Dr. Fay, and my suspicion is often wrong, is that you put these categories according to your own basis of A, B and C on the cards and that they don't represent the categories that were established on the 13th of September. In other words, that you put them on before.

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THE WITNESS: Yes.



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THE COMMISSIONER: So it is possible, of course, that you may have made the changes at the meeting.

THE WITNESSES: Changes were made.

THE COMMISSIONER: But it is also possible that you may have made the changes before you got to the meeting. I don't know.

THE WITNESS: I certainly added at the meeting. I added to the card at the meeting.

THE COMMISSIONER: The funny thing about it, though, the votes were all taken as A, B, C or D, weren't they? I may have got this wrong. They seem to have taken votes on four categories and you have participated in that.

THE WITNESS: Yes.

THE COMMISSIONER: I don't know. I just would like you to think about it overnight that there is this possibility that you did have categories of your own of A, B and C or maybe A, B and Natural and that the meeting established four categories but that your cards may represent the three categories and not the four.

That may help you to determine that you put those categories on before you went to the meeting. It may not. But that is a possibility.



Fay
cr.ex. (Strathy)

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Anyway, I think it would be best to abandon this line. It looks as though you won't finish by 4:30 anyway - abandon this line and come back to it tomorrow after we have got the original cards.

MR. STRATHY: I am prepared to do that.

Q. I would like to ask a further question on this Baby Hines, though, doctor, and direct your attention to the same page, 221, of the Minutes.

The second paragraph on page 221 says -- do you have that?

A. Yes.

Q. "Dr. Fay stated that he more or less reached the same conclusion as Dr. Hastreiter. He said that he was concerned that here is a child being identified as heart disease who was not that sick. He put the death in Dr. Hastreiter's 'Good' category."

Now it may be that these Minutes are not accurate, doctor, but it seems to me that that is not what you did initially. You did not put it in



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Dr. Hastreiter's "Good" category.

THE COMMISSIONER: Well, I say he might well have. If he had already done the A before he got to the meeting. That is all. We don't know that yet.

Now I am interrupting your cross-examination, but that is an assumption I don't think it is safe to make until we know when he put the A on.

MR. STRATHY: It does seem to me, Mr. Commissioner, that the "possible" that is on page 3 is a far cry from Dr. Hastreiter's "Good".

THE COMMISSIONER: No, but the A isn't.

MR. STRATHY: The A isn't.

THE COMMISSIONER: And we don't know when he put the A on. He may well have put "possible" and, Dr. Fay, you correct me if I am making assumptions that you know are wrong. Don't correct me if you don't know whether I am wrong or not. He may have put the "possible" on. He may have put B relating to "possible" and then he may have changed from B to A before he got to the meeting, and he may have changed as I suggested to him because of the toxicology advice that may have come later, that is all. It is possible.



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We don't know -- we don't know what happened. If Dr. Fay ever does remember what the sequence of events are, it might be of some importance. It is not -- his process of thought is not as important as the thought, that is all, unless you want to use it for the purpose, and I don't think you do, of discrediting Dr. Fay's present opinion.

MR. STRATHY: No, I don't.

Well, I wonder if we could do this, Mr. Commissioner, since it is nearly 4:30: I am in the middle of this child Hines --

THE COMMISSIONER: All right. Do you want to break off now then until tomorrow?

MR. STRATHY: Yes.

THE COMMISSIONER: I wonder if we could take a roll call now. How long do you think you will be?

MR. STRATHY: Certainly to the break in the morning.

THE COMMISSIONER: Yes.

MR. STRATHY: Maybe a bit longer.

THE COMMISSIONER: Mr. Hunt? Oh, yes, you have been through, yes.

Mr. Roland?



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MR. ROLAND: I expect I will be
an hour or maybe more.

THE COMMISSIONER: Mr. Knazan?

MR. KNAZAN: I am going to let
Mr. Olah go first and then I may have some questions,
but in any case I will be brief.

THE COMMISSIONER: Mr. Olah?

MR. OLAH: I will be about fifteen
minutes.

THE COMMISSIONER: Mr. Labow?

MR. LABOW: I would expect to be
about half an hour.

MR. SHINEHOFT: I don't think I
will have any questions.

THE COMMISSIONER: I really was
going through that because I was wondering if it
would be an advantage to start at 9:30 tomorrow
morning, that is all. I think it might. I think
we owe it to the witness to try to get him safely
out of here tomorrow.

MR. STRATHY: As long as it is
all right with the witness.

THE COMMISSIONER: Oh, yes.

You have that choice, certainly.
If you prefer to start early tomorrow to get you
away.



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THE WITNESS: I will start at
seven o'clock if I can get out of here by 5:30 or so.

THE COMMISSIONER: Well, I think
9:30 is as far as we can... The legal profession is
not as good as the medical profession in getting up
in the morning. It may be better working at night.

So 9:30 then tomorrow morning.
As long as you are here and the witness is here,
Mr. Strathy, we will go on whether anybody else is
here or not. Well, I guess I have got to be here too.

--- whereupon the hearing was adjourned at 4:30 p.m.
until Thursday, the 24th day of November 1983
at 9:30 a.m.

